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THE NATURE OF ARTHRITIS AND RHEUMATOID CONDITIONS

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Recently there were reported[1] the results of the treatment and intensive study of 400 cases of chronic arthritis in the army. This report dealt with the conditions encountered, the methods of treatment employed, the particular lines of investigation undertaken, and the general recommendations and conclusions that could be dependably based on them.

The wealth of clinical material and the lines of further thought and work suggested by these studies made it difficult to do justice to the opportunity and develop all its possibilities. Apart from the practical conclusions drawn, possibly one of the most important results achieved lay in contributing to an hypothesis on the nature of rheumatoid disabilities at large as a premise from which further effort could profitably proceed. Owing to the conditions under which the work was conducted and the purposes in view, it was deemed inappropriate to include in the above report more than the ascertained facts and closely related material. An attempt will therefore be made here to present certain points of a clinical nature, not included in the previous report, together with certain theoretical aspects, in the effort to narrow our conceptions of the problem, and hence of the field to be studied. In attempting this, some repetition of data already published will be unavoidable. It is desired to classify the general nature of the pathologic processes concerned rather than to attempt further detail at this time, and it is of course to be appreciated that the hypothesis here presented is subject to the modifications of future work now in progress.

It is certain that rheumatoid conditions are among the most common ailments that affect mankind, if indeed they do not take the leading place. It may not be appreciated by most physicians who come in contact with this omnipresent condition that arthritis is one of the diseases of which we have the oldest historical evidence. It has been shown, as one writer has put it, that it was the disease *par excellence* of the old Egyptians, and it is probable that in ages long preceding them it had already induced widespread suffering among the human race. Thus, certain of the human remains of the stone age[2] show advanced arthritic processes.

Notwithstanding the antiquity and omnipresence of this disease, however, it has remained until recently one of those conditions in which all forms of therapy are of small avail. It is true that among the ancients of Greece and Rome the benefits to be obtained from hydrotherapy were already appreciated, and it is alleged that the important influence of focal infection was known to some of the fathers of medicine. This relation was also pointed out in 1819 by Benjamin Rush;[3] but its broad application was delayed until emphasized and expanded, more particularly, by some of the Boston school of orthopedists. Since then it has been worked out in a wealth of detail by many observers. At present, therefore, the most signal individual advance in the treatment of arthritis is probably that based on appreciation of the rôle which focal infection bears to this disease. This rôle is now so widely recognized that it needs no emphasis among the better posted elements of the profession. Indeed, the pendulum has swung the other way, and radicalism along this line has reached the point at which not only all cases of arthritis but many other diseases have been assumed on insufficient evidence to be referable to this cause. As a result of this, many surgical operations have been needlessly performed and, for example, not a few sufferers have been caused added disability by extraction of many or all of their useful and sound teeth. The attempt is now being made by physicians to find a mean between these extremes, and the opportunity to study arthritis on a large scale in the army was utilized partly in seeking information on the etiologic and therapeutic limitations of the doctrine of focal infection.

Although the importance of focal infection was abundantly illustrated and is not to be in any sense minimized, the subjects of this study showed an interesting and large independence of it. It became clear that, in these younger subjects, focal infection played an analogous but lesser rôle as compared with its relation to the bulk of cases encountered in civil life. Added importance was given to the view that with chronicity the results of the removal of focal infection become less noteworthy, although there are important exceptions to this. In a regrettable number of chronic cases, and in some early instances the removal of focal infection may be of no avail whatever. The important rôle, as shown by our statistics, played by exposure and wet, and the evidence adduced by studies of the sugar tolerance, to be mentioned later, strongly suggest that this disease is not infrequently referable to causes

1. Pemberton, Ralph, and Robertson, J. W.: Studies on Arthritis in the Army, Based on Four Hundred Cases, I, Preamble and Statistical Analysis, Arch. Int. Med. **25**: 231 (March) 1920. Pemberton, Ralph, and Tompkins, Edna H.: II, Observations on the Basal Metabolism, ibid., p. 241. Pemberton, Ralph, and Foster, G. L.: III, Studies on the Nitrogen, Urea, Carbon Dioxid Combining Power, Calcium, Total Fat and Cholesterol of the Fasting Blood, Renal Function, Blood Sugar and Sugar Tolerance, ibid., p. 243. Pemberton, Ralph, and Buckman, T. E.: IV, Studies in the Relation of Creatin Metabolism to Arthritis, ibid. **25**: 335 (April) 1920. Pemberton, Ralph: V. Roentgen-Ray Evidences, Clinical Considerations, Treatment, Summary, Conclusions and Clinical Abstracts of Cases Studied, ibid., p. 351.

2. Osborn, H. F.: Men of the Old Stone Age, Ed. 3, New York, Charles Scribner's Sons, 1918.

3. Cited by Hammond, R.: Am. J. M. Sc. **156**: 541 (Oct.) 1918.

other than focal infection. Although the last named may generally play the precipitating rôle, there is reason to believe that we are now able at least to outline some of the true pathologic basis of arthritis.

THE PATHOLOGIC BASIS OF ARTHRITIS

Many instances in the large series mentioned above were caused by dysentery, influenza, pneumonia and other conditions which added importantly to appreciation of the fact that infections of diffuse types may inaugurate the same results, although the most frequent type is that resident in teeth, tonsils and so on. It is clear, however, from some of these cases, that the arthritis may be referable not solely to the apparently originating factors of dysentery, influenza or exposure, because some cases in which these were the well punctuated causes made a later significant improvement when demonstrable foci were removed. It therefore appears that foci otherwise inoperative may be made operative by a severe illness. The only alternative to this is that they have themselves been actually produced as the result of this illness. The probable mechanism here is that the original disease or exposure induces the situation which in other cases foci themselves may cause; on the basis of this situation, foci then act to perpetuate conditions for which they were not originally responsible.

Before proceeding to a discussion of the substratum of pathology which these studies have strongly indicated, it may be well to consider some of the other agents that influence the disease.

It has long been recognized by critical students of arthritis and by many of those most familiar with the various clinical applications of the roentgen ray, that exposure of an arthritic subject to this agent is sometimes productive of profound systemic benefit. It was observed by Edsall and Pemberton [4] in 1907 in two cases of advanced chronic arthritis in which the metabolism was studied when under the influence of the roentgen ray, that this benefit ran parallel to the greatly heightened catabolism which this agent produces. Therapeutic use might be made of this observation, although this has as yet been limited in its application because of the associated dangers.

The principle on which this effect depends is further illustrated by the action of radium, another agent which, according to all the evidence at our hand, hastens metabolism. Benefit is sometimes seen from the use of thyroid extract, one effect of which, as clearly proved, is to increase metabolism. Finally, muscular exercise, even in the form of massage, has long been depended on as an adjuvant and can be easily shown to be of real influence therapeutically when it can be employed. Here again the influence of this agent is to increase metabolism. It is probable that arsenic, within limits, acts much in the same way. Finally, attention must be called to one type of stimulus whose effect is not generally known, although long familiar to some close students of arthritis. This is in connection with those changes of metabolism, as yet imperfectly worked out, which follow on periods of excitement or such psychic disturbance as may, in the invalid, accompany a long railroad journey, anticipitation of an operation and the like. It is pretty well accepted that in profound mental disturbances, such as fear and presumably other forms of excitement, there is involvement of the endocrine system. Not a little experimental evidence has been advanced to relate an important rôle in this connection to the suprarenals at least. It therefore must be conceded that some of the foregoing factors may act through the intermediation of the ductless glands; but whatever the mechanism, the net result is that agents which hasten the body metabolism have beyond all possible doubt an influence for the better, especially in certain selected cases of chronic arthritis.

An attempt was made at U. S. Army General Hospital No. 9, at Lakewood, N. J., to investigate this phase of the question by studying the basal metabolism. Twenty-nine cases were investigated by Miss E. H. Tompkins and the writer, and in 20 per cent. of them the basal metabolism was found to be slightly below normal. Taken by itself, this fact can hardly be given much significance; but in conjunction with a number of other small departures from normal, it is probably justifiable to give it more value, as will be attempted later.

Studies were also carried out at the same hospital with Lieut. Goodwin L. Foster of the Sanitary Corps on the urea, nonprotein nitrogen, calcium, total fat, cholesterol and the carbon dioxid combining powers of the fasting blood. These were all found to fall within normal limits. A long series of observations was also conducted on the nephritic functions as measured by the so-called nephritic test meal, and these too were found to fall essentially within normal limits. When compared with a series of normal individuals under exactly comparable conditions, the arthritics showed a slight lag in the elimination of water, nitrogen and salt; but this was so inconsiderable as to make it appear that renal function at large is essentially undisturbed in chronic arthritis. These evidences might be interpreted as showing a very mild disturbance of nephritic function, but so mild, indeed, as to be regarded as only a sequel to underlying pathologic processes and in no sense causative of the symptoms of the disease.

There can now be mentioned, however, a line of investigation which gave more interesting results. The writer has previously demonstrated [5] a definite relation between the intake of food and the incidence and perpetuation of the symptoms of chronic arthritis. This relation can be put to therapeutic application in selected cases. Although the respective rôles of the three foodstuffs protein, fat and carbohydrate have not been entirely worked out, the evidence strongly suggested that at least carbohydrate was caught up in some important way in this connection. With the aim of determining this definitely, studies were therefore undertaken by Lieutenant Foster and the writer on the blood sugar and sugar tolerance in chronic arthritis. Without going into details, which have been fully reported elsewhere,[6] it is sufficient to say that arthritics show a lowering of the sugar tolerance more or less proportional to the severity of the disease. Quite apart from arthritis, a factor which seems frequently to cause a lowered sugar tolerance is precisely that which seems very frequently to cause arthritis, namely, focal infection; and it was possible to demonstrate in certain cases a striking return to normal of a lowered tolerance coincident with removal of the focus and recovery of the subject. The accompanying chart will serve graphically to illustrate the return of a greatly lowered sugar tolerance to nor-

4. Edsall, D. L., and Pemberton, Ralph: The Nature of the General Toxic Reaction Following Exposure to the X-Rays, Am. J. M. Sc. 133: 426, 1907.

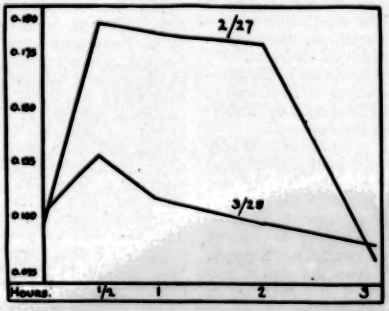
5. Pemberton, Ralph: Am. J. M. Sc. 158: 678 (May) 1917.

6. Pemberton, Ralph, and Foster, G. L.: Studies on Arthritis in the Army, Based on Four Hundred Cases, III, Studies on the Nitrogen, Urea, Carbon Dioxid Combining Power, Calcium, Total Fat and Cholesterol of the Fasting Blood, Arch. Int. Med. 25: 243 (March) 1920.

mal, coincident with the removal of focal infection and cure of the arthritis. It was found, however, that the sugar tolerance was sometimes markedly lowered in cases in which no focal infection could be demonstrated. It was also found that in certain chronic cases from which all foci had apparently been removed, the sugar tolerance still remained greatly lowered. It was furthermore found that in cases of arthritis in which there was a lowered sugar tolerance this tolerance tended to return to normal with improvement of the patient irrespective of the type of therapy employed, even in the presence of apparently causative foci of infection. In other words, a lowered sugar tolerance was pretty clearly indicated to be an intermediary or concomitant step in the pathology of arthritis.

A lowered sugar tolerance is not be interpreted, however, as peculiar to this condition. Apart from the important studies of Hamman and Hirschman,[7] and Janney and Isaacson [8] and others, on thyroid conditions and nephritis, a lowered sugar tolerance has been observed in cancer.[9] A high blood sugar and presumably therefore a lowered tolerance has been observed in furunculosis.[10] Whether it accompanies noninflammatory processes, such as follow traumatism, etc., is yet to be determined, though it very likely does if the involvement is large.

A lowered sugar tolerance is apparently evidence of disturbance, broadly speaking, of some of the oxidative or combustive processes, and it is probable that this is the explanation of its occurrence in arthritis. Reference will later be made to the work of Cole and Blake, who have shown that the action of pneumococcus and *Streptococcus hemolyticus* on blood in vitro is in part to produce methemoglobin. This result may conceivably be one of the factors making for suboxidation of an imponderable kind in arthritis. It is probable that as our knowledge of the conditions accompanied by lowered sugar tolerance become better known, the principle of reducing the intake of sugar-producing substances will be extended with the aim of adjusting the burden to suit the capacity to care for it, and this suggestion is submitted for consideration.



Contrast after twenty-nine days in sugar tolerance of a soldier with severe arthritis who made an abrupt convalescence after tonsillectomy. The lower curve, showing a normal tolerance, was obtained fourteen days after the tonsillectomy.

There was therefore found in these observations experimental corroboration of the premises on which the dietetic therapy, mentioned above, is based; and a man with a severe case of arthritis, who recovered entirely by the maintenance of a low diet, showed a return to normal of his previously lowered sugar tolerance.

In this connection it is interesting to note that in a very careful study of the creatin metabolism in this disease, Lieutenant Buckman, associated with the writer on the arthritic service at U. S. Army General Hospital No. 9, obtained results which indicate pretty clearly that there is in a large proportion of cases an elevation of the blood creatin which sometimes tends to decline with the improvement of the disease. The topic of creatin metabolism is too large to justify discussion here, but it is now accepted by most leading workers in this field that creatin bears a definite relation to carbohydrate metabolism. A review of the literature is presented in the studies on arthritis already referred to.

For purposes of the later development of an hypothesis it is necessary to mention certain other definite relations between the food intake and symptoms of the disease. It can be clearly illustrated by any one, as the writer has previously reported, that in the period of postoperative starvation which follows many abdominal or other operations on the subject of chronic arthritis, there is generally a sharp amelioration in both subjective and objective symptoms. This may amount sometimes to their entire disappearance. On the return of such an individual to the previous generous diet there is sooner or later a return of the symptoms in their previous severity, although for a time, while depletion is being atoned for, an increased caloric intake may be unproductive of symptoms. It is of the highest interest to note that this improvement has been shown to take place even in the presence of demonstrable and apparently causative infection, although this fact should not be made the excuse for dietary treatment in the presence of removable foci. Illustrative cases will be mentioned later.

Much caution should be exercised in prematurely attributing to operations of various sorts, tonsillectomy, appendectomy and removal of the colon (Lane's procedure), the benefits to an arthritis which are almost sure to ensue in the early stages of convalescence.

It thus appears that successful treatment of chronic arthritis on the basis of a reduced dietary achieves its results by catering to a weakened function, namely, that of which the lowered sugar tolerance is one evidence. It is to be borne in mind that a lowered sugar tolerance is probably the expression of disturbance of a widespread function probably also concerned with the utilization of protein and fat.

At this point can probably best be mentioned a corollary of the preceding general truth which is of much interest and of immediate application to our problem. It has been stated above that the ingestion of carbohydrate in large amounts is sometimes harmful in chronic arthritis. It would therefore seem reasonable to suppose that a subject of diabetes in the later stages, a period when ingested carbohydrate remains nearly wholly utilized and is passed out of the body, would be conspicuously free from rheumatoid symptoms of whatever nature. It is obvious that we are here dealing with only one point of a large problem, and that well marked instances should be selected for test-

7. Hamman, Louis, and Hirschman, I. I.: Studies on Blood Sugar, Arch. Int. Med. **20**: 761 (Nov.) 1917.
8. Janney, N. W., and Isaacson, V. I.: The Blood Sugar in Thyroid and Other Endocrine Diseases, Arch. Int. Med. **22**: 160 (Aug.) 1918.
9. Rehdanburg, G. L.; Bernhard, Adolph, and Krebbiel, Otto: Sugar Tolerance in Cancer, J. A. M. A. **73**: 1529 (May 24) 1919.
10. Gettler, A. O., and St. George, A. V.: The Values of Modern Blood Chemistry to the Clinician, J. A. M. A. **71**: 2033 (Dec. 21) 1918.

ing it. Experience in the general medical wards under the writer's charge at the Presbyterian Hospital, Philadelphia, has suggested that rheumatic affections are at least unusual in well marked diabetes, but an effort was made to control this impression by the wider experience of others particularly interested in this field. Discussion of this point with Capt. Frederick M. Allen, M. C., in charge of the diabetic service at U. S. Army General Hospital No. 9, developed the fact that in his large experience with diabetes he had rarely if ever come across intercurrent arthritis or rheumatism. The matter was then taken up with Dr. Elliott P. Joslin, who has kindly written as follows: "I remember no case of rheumatic fever in diabetes and no case of diabetes for which I ever prescribed a salicylic acid preparation for joint pains. The latter statement is good evidence of my feelings that I have not seen rheumatism, acute or chronic, in diabetes." This point is not lightly to be ignored. In the course of the arthritic and diabetic services at the army hospital, one case was observed in which there was a doubtful or slight arthritis in one ankle and a mild form of diabetes which was easily controlled. It is of course obvious, however, that the diabetic with symptoms so mild that the disease is controlled on a high level of food intake may by the same token develop rheumatism. There is here an equation, the solution of which depends on the value given its variables.

It seems fair to conclude, therefore, that in the presence of conditions which prevent access to the economy, in important amounts, of ingested carbohydrate, arthritis and rheumatic disability are at least unusual.

While discussing matters relating to diabetes, it may be pertinent to mention at this point another consideration arising out of very similar premises. It has long been appreciated by close students that arthritis is a disease whose incidence is markedly greater in the later decades of life, namely, around and beyond 40 years of age. Arthritis in the young is, of course, not a rarity, and some of the most refractory types are seen at this age; but, by and large, the problem in young people is numerically small as compared with that presented by older persons. It is probably justifiable to relate this, in view of the known and suggested facts, to the so-called age curve of metabolism. The operation of this curve in diabetes is succinctly presented by Joslin,[11] who says:

> Greeley [12] has pointed out the analogy between the steadily decreasing severity of diabetes as age progresses and the decrease in the metabolism; and the curve of basal metabolism coincides exactly with the curve of severity in diabetes, being greatest in infancy and childhood, and least in old age. The severity of a mild case of diabetes is at once increased by the incidence of an accident increasing basal metabolism (fever, infections, goiter).[13]

Enough has probably been suggested in the preceding text to indicate that this relation is almost the exact opposite to that which obtains in chronic arthritis. Any critical observer can satisfy himself that the incidence of some conditions falling under the foregoing general head, such as pneumonia and pregnancy, may be followed by temporary improvement or entire surcease of symptoms in chronic arthritis. Indeed, so much is this the case that one of the accepted methods of treating chronic arthritis is to induce fever, heightened metabolism and the picture of a severe infectious process by means of nonspecific protein injections. Reference has elsewhere been made more fully to some of the factors on which benefit from this may depend.[1]

It was earlier remarked that the basal metabolism is slightly below normal in 20 per cent. of cases, and it is much more likely to be below than above normal. This departure was given small significance; but, viewed in conjunction with the truth just mentioned, it is entirely proper to accord it more weight. It is to be borne in mind, furthermore, that the figures representative of the total metabolism are only summation figures, and that much may take place to disturb the intermediary metabolism without expressing itelf in such totals.

CAUSE OF DELAYED ONSET

There can now be considered at somewhat greater length than was appropriate in the report of the studies mentioned above, a theoretical explanation of the delayed onset of arthritis, following an obviously causative systemic infection. This onset was illustrated in an important number of soldiers. Attention was directed to the fact that, coincident with or some weeks after recovery from such conditions as dysentery, influenza, pneumonia and certain surgical accidents, there sometimes developed sharp outbreaks of systemic and severe multiple arthritis in soldiers who in many cases had never had previous attacks. It is improbable that this can be entirely explained at present, but at least one conceivable explanation at hand fits in with certain definitely demonstrated facts of this disease and seems to be corroborated by close analysis of the cases studied. The writer has elsewhere adduced evidence to show that chronic arthritis may have an onset referable to the food intake alone in certain exceptional cases, although the basis for this had probably been laid by some unrecognized circumstances. Certain it is that curtailment of the food intake may have sharply beneficial results. It therefore seems reasonable to suspect that some cases of chronic arthritis that develop contemporaneously with convalescence from a severe disease may do so because of the induction of the condition expressing itself in a lowered sugar tolerance on which an added strain is thrown by the increased and even forced intake of food usual at this time. Indeed, the common experience of a poor appetite coincident with early convalescence from many diseases may be Nature's own attempt to safeguard the individual from placing undue strain on a weakened function, and carries its own moral. In other words, Nature's warning, which we interpret subconsciously and rather grossly as a loss of appetite, may rest fundamentally on the very definite fact that the subject is unable properly to care for large amounts of those foodstuffs that yield substances requiring oxidation.

A clear-cut instance of the recrudescence of an arthritis following recovery from febrile jaundice in the presence of dental infection is given in Case 33, Mrs. K., a Red Cross worker, in the report [1] mentioned above, when she returned to her normal intake of food. This patient for some years had had various arthritic disability and deformity of all finger joints. She had tonsillar and dental foci, March 2, 1919, and gave a high sugar curve (low tolerance). Tonsillectomy was performed, April 2; five days later, after two days of sharp, unintended low feeding, her hands showed marked improvement. When she resumed her full diet, their previous condition returned in all its severity.

11. Joslin, E. P.: Treatment of Diabetes Mellitus, Ed. 2, Philadelphia, Lea & Febiger, 1917, p. 112.
12. Greeley, H. P.: Boston M. & S. J. 175:753 (Nov. 23) 1916.
13. In view of the work reported here and that previously reported, part of the unfavorable influence of intercurrent infections in diabetes is possibly due to further lowering of the sugar tolerance.

She then developed acute catarrhal jaundice with extreme obstipation and fecal impaction. During the ten days of extremely low diet, necessitated by nausea, her joints entirely cleared up again and remained so until she was up and around eating as before. Her phalangeal arthritis then returned. Critical studies of the creatin and nitrogen metabolism of this case were made by Lieut. Thomas Buckman, M. C., and have been reported.[2]

Case 52 of the studies on arthritis in the army also illustrates the same phenomenon, as does more particularly Case 22, in which the same result was intentionally induced. Other cases likewise have been reported.[1] If this phenomenon can occur in respect of a previously existing arthritis, as it unquestionably can, it is more than possible that it may also occur in the production of arthritis de novo, and the writer has observed some such apparent instances.

The attempt has now been made to show, on the one hand, that there is in arthritis a difficulty in the utilization of food as indicated by the therapeutic effect of a reduced diet and by the great frequency of a lowered sugar tolerance; and, on the other hand, that agents which hasten the metabolism as a whole may have a markedly beneficial influence.

SIGNIFICANCE OF FREQUENCY WITH WHICH MUSCLES AND JOINTS ARE AFFECTED

Let us now turn to the sites at which the rheumatic process most frequently expresses itself, with the idea of correlating them with these facts and finding some common denominator. The rheumatoid state at large affects two chief types of structures, namely, the muscles and the joints. Its influence is by no means confined to them, and neuritis is an admittedly frequent manifestation. Furthermore, many of the neighboring joint structures may be involved, such as the tendons, but in general the field of distribution is sufficiently covered by the foregoing statement.

It is perhaps not generally appreciated that the joints are structures whose blood supply is poor as compared with most of the important organs of the body. Apart from the rather meager data in textbooks relating specifically to this point, authority for this statement is found in the exhaustive studies on the gross and microscopic morbid anatomy of arthritis deformans by Nichols and Richardson.[14] These certainly constitute the most complete studies in this country, and probably elsewhere, on the anatomic phases of the problem.

In a personal conversation, Dr. Nichols has made the unequivocal statement that the blood supply of the joints, per se, is definitely poor. In fact, the joint cavities themselves have no blood supply and depend on the synovial fluid, which notoriously lacks the active blood elements that condition nutrition and metabolism. Thus, blood carries about forty times as much oxygen as does the same volume of plasma.[15] It is therefore probable that the oxidative metabolism of the joints or metabolism in the neighborhood of the joints is low and less intense as compared with other structures. If, then, rheumatic disturbances are characterized by a difficulty somewhere in the body in completing metabolic functions; if lessening the burden of these functions by cutting down the food intake is beneficial; if stimulation of these functions to greater activity is also beneficial, it is easy to believe that the rheumatic state would here find one of its expressions. In point of fact, this syllogism is well substantiated by the notorious benefits of hyperemia induced at these sites. This principle is widely utilized in the form of baking, hydrotherapy and electricity, all locally applied. Indeed, local exercise itself under certain conditions is of definite avail. It is also common knowledge that the stiffness and general disability of chronic arthritis are worse in the morning when the parts involved have been long at rest and the whole bodily as well as the local metabolism has been on a lower plane. As the day wears on and activities are resumed, borderland and mild cases show large increase of function or even entire disappearance of symptoms.

The other chief site of rheumatic disturbance mentioned, however—the muscles—presents another difficulty, the explanation of which may at first blush appear paradoxical. There is not here the same question normally of lower blood supply and nutrition. It is generally recognized, however, that the muscles and the liver constitute the chief sites of the body's metabolism, especially of carbohydrate. Enough has been advanced above at least strongly to suggest that the metabolism or oxidation of carbohydrate is importantly involved in the process which results in rheumatism. Carbohydrate is probably not involved alone, and its end-products are probably the active factors concerned in this relation; but since it constitutes one of the three leading subjects of metabolism of the body, and since about half of the ingested protein goes to carbohydrate, this general involvement is most easily considered in terms of it. It is conceivable, therefore, that we have here an explanation of the frequency of myositis as a rheumatic manifestation. The condition which expresses itself in a difficulty of metabolism, such that hastening that metabolism or reducing the necessity for such metabolism is of benefit, would not inconceivably evidence itself at one of the chief sites of that metabolism. Thus, massage, exercise and heat find wide utility in their application to the muscles, and it is generally accepted that exercise (massage) increases the metabolism of only the glycogen (carbohydrate) of the muscle, and within physiologic limits does not increase the metabolism of the nitrogenous elements. There are also other factors operative here which are now the subject of investigation.

We therefore have at least a partial explanation for the occurrence of rheumatoid conditions in the two types of structures in which it chiefly occurs, namely, in the joints, because oxidative metabolism there is necessarily sluggish or slight, and in the muscles, because in them takes place an important part of the metabolism of at least one substance known to stand in some relation to this disease.

FACTORS AFFECTING THE OXIDATIVE FUNCTION

Let us now turn to a consideration of some of the factors that are known to induce a lowering of metabolism or oxidation, as we may tentatively call it. Cole [16] has shown that living pneumococci convert hemoglobin into methemoglobin, and Blake has demonstrated that *Streptococcus viridans* has the same property. This organism, as is well known, plays apparently a large rôle in the infectious origin of arthritis. As Wells [17] points out, this relation may play a part in the effects of infections with these organisms. It is possibly unnecessary, however, to introduce this consideration

14. Nichols, E. H., and Richardson, F. L.: J. M. Res. 21: 149 (Sept.) 1909.
15. Barcroft: The Respiratory Function of the Blood, Cambridge, 1914.
16. Cole: J. Exper. Med. 20: 347, 366, 1914.
17. Wells: Chemical Pathology, Ed. 3, Philadelphia, W. B. Saunders Company, 1918, p. 225.

in explanation, as the recent investigations on the respiratory function of the blood by Barcroft, Haldane, Yandell Henderson and others have afforded other and wider bases for hypothesis.

The studies of Barcroft and his co-workers on the respiratory functions of the blood have opened up a wide and fundamental field of thought not only in physiology but also in their application to the phenomena of clinical medicine. The work of Yandell Henderson and his collaborators in this country has further elaborated these studies, which now constitute a highly specialized topic. It is recognized, for example, that the balance of acid and base elements is not constant in the blood but varies according to the areas of different tension of carbon dioxid through which the blood passes. The determination of the hydrogen ion concentration or the alkali bicarbonate establishes only one of the values which the blood may have.[18] The work of Barcroft has abundantly proved that without change in the dissociation curve of hemoglobin or hydrogen ion concentration, there may be in the blood definite amounts of α-hydroxy acids, of which lactic, though not necessarily concerned, is a type. Indeed, this phenomenon makes possible a pretty adaptation to the conditions of high altitudes.[19]

It is therefore appreciated in a considerable wealth of detail that the delivery of oxygen by hemoglobin to given sites is conditioned on recognized physical factors at all times operative normally. Thus, the areas of varying tension of carbon dioxid in the circulation, from whatever cause; the temperature of the blood at a given spot; the barometric pressure; factors within or without the economy making for acidosis, and so on, all affect the oxidative function locally or even systemically.

Once the relation of hemoglobin or the oxidative functions of the blood to arthritis has been established, these considerations find immediate application. The topic is much too large to be presented here, and is now the subject of studies in relation to arthritis. Suffice it at the present time to predicate herewith, subject to later modification, that rheumatic and arthritic phenomena find their chief explanation in these principles.

A WORKING HYPOTHESIS

There have now been presented the necessary facts and theoretical considerations for the formulation of a working hypothesis of this disease. It is possible to indicate why arthritis and rheumatism so frequently jump from one place to another in an apparently meaningless way. It would seem to be because there is a lowered respiratory or metabolic capacity, possibly in the circulating blood. This is able to achieve a certain amount of its normal function, but not all; and those sites at which metabolism is normally most sluggish are among the first to suffer. Hyperemia of a part involved, intended or accidental, suffices often to restore metabolic conditions locally to approximately their normal level; but this does not necessarily relieve the general situation, and the same phenomena may then occur elsewhere. This "quantitative" quality of arthritis is one of its outstanding phenomena. An explanation can also be advanced as to the rationale of mysotis or arthritis when due to exposure. As mentioned above, unmistakable physiologic evidence is at hand to show that reduction of temperature immediately lowers the dissociation curves of hemoglobin for oxygen.[20] By the same token, the well known effect of heat in rheumatism and arthritis finds its explanation in the corollary to this, whereby the dissociation curve is raised. The latter explanation is probably more specific than the usual one of hyperemia induced by heat, though obviously both factors are present.

It is not difficult to believe, therefore, that prolonged exposure or chilling of part of the muscular system would induce a lesser delivery of oxygen by hemoglobin. We would then have a secondary stage in the pathology of arthritis without intermediation of that focal infectious agency which seems usually to exist. This consideration finds some support in the clinical observation on a series of 400 arthritic soldiers referred to above, namely, that this group of soldiers tends as a whole to recover more promptly than do patients at large in civil life, where exposure plays a very trifling rôle. At any rate, in this statistical fact of the induction of rheumatism by exposure there is strong evidence that infectious foci are not the only agents capable of starting the chain of events that result in rheumatism or arthritis. That this chain should be referable to one agent alone necessitates an assumption difficult of defense. It is safer, and it is certainly more reasonable to believe that a variety of factors, many types of infection, exposure to cold and wet, chronic intestinal conditions of which we have only imperfect knowledge, and possibly even less ponderable interglandular disturbances may induce the substratum, partly illustrated by a lower sugar tolerance, which is shown to accompany this disease so closely.

It is also possible to attempt an explanation of certain other well recognized but hitherto inexplicable phenomena accompanying arthritis. It has long been recognized that chronic sufferers from this disease undergo exacerbations that seem to be sharply related to disturbances of the weather. This is so definitely true that certain types of climates are recognizedly detrimental and others equally advantageous in their influence on this disease. If disturbance in the respiratory functions of the blood is a factor in the disease, it is almost axiomatic that wide fluctuations of the barometer and humidity would affect these cases, since the percentage saturation of hemoglobin by oxygen is a function of the partial pressure of oxygen in the alveolar air.

GENERAL LINE OF TREATMENT

It is not the purpose here to emphasize the practical aspects of treatment on the basis of the pathology discussed. It may not be amiss, however, to point out in a general way the line which this must take. As there is no single specific arthritis, it follows that advantage should be taken of the effect of all contributory agents. Treatment should be postulated on the removal of the exciting cause first, when this is possible. This consists in the majority of cases in the removal of some focus of infection. In chronic cases the underlying physiology may become so disturbed that removal of the exciting agent does not suffice to restore it. Under these circumstances, and also when the exciting agent for a variety of reasons cannot be removed, it becomes necessary to adjust the burden to suit the altered metabolism, as the basis on which subsequent therapy can be established. Such agents as arsenic, the iodids and hydrotherapy may then have results which alone are too often disappointing.

18. Haggard, H. W., and Henderson, Yandell: J. Biol. Chem. 39: 163 (Aug.) 1919.
19. Barcroft: The Respiratory Function of the Blood, p. 272.
20. Barcroft: The Respiratory Function of the Blood, p. 158.

The institution of a reduced diet in suitable cases is best achieved by determining over a period of about ten days the caloric intake of the patient under the average conditions of his invalidism. This gives an approximation as to the degree to which the caloric intake must be reduced in order to spare him a possible surfeit. If the determined intake is high, a rather sharp reduction can be established without detriment to his nutritional needs, and spare him at the same time possibly as much as 1,000 calories. If, on the other hand, the determined intake is low, much caution must be observed, and the procedure becomes more difficult and hazardous. It is not possible to discuss here further details in this connection, as these have been fully given elsewhere.

One of the outstanding lessons derived from the study of arthritis among large numbers of soldiers was to the effect that various accessory lines of treatment could be profitably combined, although often unavailing alone. External measures, such as hydrotherapy, have undoubtedly real value but have fallen in some disrepute because of their frequent failure and because of the injurious consequences from them when pushed in the effort to obtain results. Used cautiously, however, hydrotherapy, massage and various medicinal agents, when administered in conjunction with a cautiously reduced diet, may carry benefit far beyond the point that would otherwise have been reached. It is strongly recommended that no attempt be made to treat cases by the combination of measures here outlined without familiarity with the dangers and limitations that have been discussed elsewhere at length.

CONCLUSION

It is not practicable to discuss at this time a considerable number of other interesting factors standing in close relation to arthritis, but it is desired definitely to indicate in this brief contribution the domain of physiology in which, from the data now at our command, the explanation of this disease is apparently to be found. It is believed that arthritis and rheumatoid conditions have not been heretofore critically referred to definite physiologic principles and facts. It remains to plot more points, so to speak, on the curve of this hypothesis. Virtually all the phenomena of the disease are explainable on the basis outlined above. Apart from this tentative explanation of the etiology and symptomatology of arthritis, various lines of study and treatment are additionally suggested and will be made the subject of later contributions.

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The Insidious Trichina.—The approach of the Christmas season prompts the United States Department of Agriculture to issue a warning against eating pork unless it is well cooked. At this season especially, quantities of pork products are prepared in homes and on farms as well as commercially, and following the holiday comes an increase in the number of cases of trichinosis. We are reminded that no matter how healthy the animal may be, how excellent the meat looks, pork may nevertheless contain trichina. Those products which pass federal inspection are usually safe, but those prepared on farms or in homes are frequently undercooked, the meat has not been inspected, and cases of this painful disease follow. A rule elaborated by a Danish investigator for killing all trichina demands that the meat be cooked from fifteen minutes in summer to eighteen minutes in winter for each pound of weight if put into boiling water, keeping the water boiling throughout the cooking process. If the meat is put into cold water, half the time required to bring the water to a boil may be deducted.

CEREBRAL THROMBOSIS AND ABRUPT SLOWING OF THE CEREBRAL CIRCULATION *

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To the three circulatory catastrophes, hemorrhage, embolism and thrombosis, which suddenly affect the brain, a fourth may be added which, because of its occurrence in weakened states of the circulatory organs, may conveniently be called abrupt slowing of the cerebral circulation. From the therapeutic standpoint, thrombosis and abrupt slowing are most important, for attention to the mechanism of their occurrence in arteriosclerosis may lead to the adoption of measures for their prevention.

Cerebral hemorrhage is preceded by few warning signs, perhaps by none, for the condition of the blood vessels within the cranium can only be surmised. High blood pressure, per se, so popular at present as presaging future attacks of apoplexy, is not the only important factor in the incidence of cerebral hemorrhage. The latter most often occurs in the presence of localized disease of the blood vessels, of which miliary aneurysm and atheroma are common terminal results. The benefit of treatment used for the control of hemorrhage already begun is extremely slight; the damage to brain substance is irreparable, and if important structures are injured the affected individual will show evidences of his disordered nervous system during the remainder of his life.

Cerebral embolism gives no warning; treatment for the condition when the latter is recognized can do nothing more than minimize the damage to brain substance, and if the vessel occluded supplied important structures, some disturbance of function, as a result of the subsequent softening, is likely to remain.

Cerebral thrombosis, in the sense of a clot developing in situ, becomes neither more nor less in effect than an embolus, and when sufficiently extensive blocks the vessel in which it forms. If the collateral circulation is not quickly established, a definite vascular area is deprived of blood. The practical difference between the two lies in the fact that embolism cannot be predicted or prevented, while not only may the liability to thrombosis be foretold, but much can be done to delay, if not permanently circumvent, its occurrence.

ATTACKS CAUSED BY SLOWING OF CIRCULATION

Fortunately, not all of these sudden cerebral attacks are due to hemorrhage, embolism or thrombosis. The more or less mild phenomena characterized by transient attacks of dizziness, amnesia, aphasia, muscle paresis, paresthesias and the like, occurring in patients with generalized arteriosclerosis either with or without associated high blood pressure, seem to depend on a more or less abrupt slowing of the cerebral circulation carried to a degree at which a localized area of the brain is temporarily deprived of its customary amount of arterial blood. Attacks with a more extensive distribution, simulating the hemiplegias due to actual brain destruction but transitory in nature, may occur; and since these have received some especial notice in the literature, a brief discussion of them will be given.

* Read before the St. Luke's Clinical Club, Sept. 24, 1920.

In 1906, Langwill[1] reported the histories of two patients who were the subjects of hemiplegia, one, complete on the left side, the other on the right, with aphasia. The symptoms cleared up suddenly after a few hours, but recurred a number of times, finally remaining absent for several years. Langwill summarized with the statement that "the characteristic features of such an attack would seem to be best explained on the hypothesis of the existence in such patients of a temporary arterial spasm involving a portion of the central vascular supply . . . associated with the condition of hypertonus in sclerosed arteries."

In the same year, Edgeworth[2] reported two cases which "show that phenomena due apparently to temporary arterial spasm in the cerebral circulation may assume forms other than hemiplegia." One of his patients was mentally confused for some hours, and had twitchings of the left face, leg and arm, and hemiparesis from which he recovered by 4 o'clock of the same afternoon.

Reports by other observers along the same line followed. Russell,[3] Allan,[4] Heard,[5] Osler[6] and others report similar cases of transient inhibition of cerebral function, and generally agree that arterial spasm in one of the cerebral arteries best explains the underlying pathologic condition. Parker,[7] in a careful review of the subject in 1909, discussed the various possible causes of these transient attacks, and concluded with the statement that "a great number of transient paralyses in various diseases appear to be caused by acute localized brain anemia."

Notwithstanding the acknowledged authority of the adherents of the vessel-spasm theory, there are several reasons why it seems insufficient to explain all cases of transient cerebral disturbance occurring in cases of arteriosclerosis.

In the first place, the theory rests on a foundation of conjecture only. There is little evidence, either of a pathologic or of an experimental nature, to support the belief that isolated spasm of the cerebral vessels may occur as a result of conditions arising in the body. The view is opposed on anatomic grounds. "In contrast to the arteries of the extremities with their strong muscularis and adventitia, the cerebral arteries show strikingly thin walls with relative poverty in elastic elements."[8]

In the second place, in most of the cases reported the attacks have occurred during sleep, shortly after awakening or on getting out of bed. A number of them came at a time when fatigue was a paramount feature. These circumstances would seem in some way to be immediately responsible for the attacks, and if this assumption is correct it seems strange that the same condition is not more frequently seen in other peripheral vessels where the anatomic conditions suitable for its production are more favorable.

A more satisfactory explanation of the phenomenon in question is gained from a consideration of the nature of the cerebral circulation and of those factors outside the cranial cavity which constantly influence the circulation within it.

The criteria by which the body circulation is judged cannot be used in determining abnormalities in the cerebral circulation, for while the former is to some extent open to direct examination, a knowledge of the integrity of the latter must be based on observation of brain function.

The circulation of blood through the cerebral vessels is more in the nature of a passive flow than of an active current. Leonard Hill[9] states that "the cerebral circulation is controlled by a comparatively weak (if any) local vasomotor mechanism, and passively follows the changes in the general circulation. . . . When in any part of the body the arteries contract, the blood volume in the area diminishes, the veins empty, the whole organ shrinks in size. Since in the closed cranium the brain cannot shrink, the cerebral capillaries must become congested with venous at the expense of arterial blood, if the cerebral arteries are constricted."

It is to this abnormal increase of venous over arterial blood that the name "cerebral anemia" unfortunately has been applied. The phenomenon is in reality an acute passive congestion, or passive slowing of the cerebral venous circulation. It will be, then, not the volume of blood in the brain which determines the proper nourishment of that organ, but rather the proportion of arterial to venous blood. This condition of passive congestion is brought about whenever the quantity of blood discharged into the cerebral arteries in a given period of time is diminished.

One of the important conditions necessary to the maintenance of the normal circulation through the brain is that sufficient blood, per unit of time, be returned to the right heart. Any factor that impedes the return of blood to the right heart decreases the rate of blood flow to the brain, and if this retardation becomes sufficiently marked, a condition of cerebral anemia results.

In many individuals in whom there is long standing arteriosclerosis there exists a marked diminution of general muscle tone and consequently a loss of that support to the venous circulation which firm musculature affords. If, in addition, the normal reciprocal action of diaphragm and abdominal muscles is interfered with, the burden of returning the blood from the abdomen and lower limbs falls on the vessels themselves, and with a failing of vasomotor tone a stagnation in the splanchnic veins occurs, the amount of blood returning to the right heart is diminished, and the quantity of blood in the arteries is reduced. The effect on the brain of this widespread anemia depends to a considerable extent on the condition of the cerebral arteries. In the young and in persons without vessel sclerosis, the result is a widespread slowing of the circulation in the brain, which may be followed by dizziness, tinnitus, fainting, or by a generalized convulsion. But when sclerosis has begun, the effect of the normally abrupt angulation of the cerebral arterial trunks at the base of the brain becomes a determining factor, and that vessel into which the blood is driven with the greatest difficulty bears the brunt of the diminished pressure, and in its terminal branches the flow is excessively retarded.

1. Langwill, H. G.: Transitory Hemiplegia, with Notes of Two Cases, Scot. M. & S. J., June, 1906, p. 509.
2. Edgeworth, F. H.: On Transitory Hemiplegia in Elderly Persons, Scot. M. & S. J. **20**: 414 (Nov.) 1906.
3. Russell, William: Intermittent Closing of Cerebral Arteries, Brit. M. J. **2**: 1109 (Oct. 16) 1909.
4. Allan, G. A.: Arterial Spasm in the Brain Associated with Transient and Permanent Paralyses, Glasgow M. J. **74**: 25 (July) 1910.
5. Heard, J. D.: The Significance of Transient Cerebral Crises and Seizures as Occurring in Arterio-Sclerosis, Edinburgh M. J., Series 3, No. 5, 417 (Nov.) 1910.
6. Osler, William: Transient Attacks of Aphasia with Paralysis in States of High Blood Pressure and Arterio-Sclerosis, Canad. M. A. J. **1**: 919 (Oct.) 1911.
7. Parker, G.: The Causes of Transient Cerebral Paralysis, Bristol M.-Chir. J. **27**: 15 (March) 1909.
8. Bennet and Triepel, in Curschmann's Text Book of Nervous Diseases **2**: 669, 1915.
9. Hill, Leonard: Experimental Pathology of Cerebral Circulation, in Allbutt and Rolleston's System of Medicine **8**: 13, 1910.

It is an observed fact that the bodily distribution of the effects of localized anemia and of thrombosis are similar. In the two conditions the results are due to disturbances in areas supplied by the most distant branches of the affected vessels. Thus, there is rarely seen a thrombosis in a small branch coming off low down, as in the internal capsule or base, unless there is actual local disease of the vessel, such as is seen in syphilis. When pressure fails, the top of the arterial tree feels the loss first. Subsequent attacks of transient local anemia and thrombosis will appear in the same areas, as a rule.

During the years 1910 and 1911, in work on the problem concerned with the relationship of relaxed abdominal musculature to cerebral anemia, it was noticed that in some arteriosclerotics with ptosis and relaxation of the abdominal muscles the customary drop in systolic pressure on standing after lying did not occur.[10] It was assumed that the hypertension served to prevent this fall. Further observation of these patients and of others of the same type has brought out the fact that there is a definite relationship between the occurrence of certain subjective symptoms experienced by arteriosclerotics and a drop in blood pressure. In fact, these symptoms are similar to those complained of in the relaxation cases with persistently low pressure, and consists of subjective sensations of muscular weakness, faintness and dizziness on standing and, as in the relaxation cases, they are relieved by lying down, by support of the splanchnic circulation and by vasomotor stimulants.

One of the early patients has had during the last year one attack associated with threatened syncope and paresthesias of one side of the body. Both systolic and diastolic pressures were found to be lower than she had been accustomed to show, and with a return of the pressures to their former levels the symptoms disappeared. It would seem that in certain types of these arteriosclerotics we are dealing with a condition similar to that which occurs in patients with relaxed abdominal walls, and that with splanchnic vasomotor fatigue a drop into the splanchnic vessels occurs, followed by a diminution in the cerebral arterial pressure and a consequent slowing of the cerebral circulation. In a number of cases transitory attacks of dizziness, sleeplessness, paresthesias and general weakness have followed attempts to lower blood pressure by the methods commonly recommended. Similar experiences have been noted by others.[11]

THERAPEUTIC MEASURES

Treatment directed to the lowering of blood pressure in a patient who has not been for some time under observation may be fraught with disastrous consequences, for the pressure reading obtained at the first examination, while considerably higher than what is supposed to be normal, may be too low for that individual under the conditions existing at the time the examination is made. To relieve the symptoms present at that moment a rise in pressure may be necessary. Russell [9] well says:

> The feeble circulation has to be recognized behind thickened and incompressible vessels; see to it that you are not deluded into thinking that there is a strong heart because there is a high hemomanometer reading.

Whatever may prove to be the primary cause of the cardiovascular degeneration underlying the phenomenon in question, all treatment directed to the prevention of cerebral thrombosis and localized cerebral anemia must have for its ultimate object the prevention of slowing of the circulation within the brain. As with many other conditions that afflict the human body, treatment of a preventive nature should be instituted long before the occurrence of attacks which at once call attention to the fact that the disease is already well advanced. When cerebral arterial sclerosis dominates the picture, these attacks may come only when the limits of compensation are nearly reached and may at once permanently destroy the affected area. But in a great majority of cases there have been suggestive signs, unwarranted by the stage of the disease in the cerebral vessels themselves, which serve to put patient and physician on their guard and lead to the institution of treatment.

Any intelligent selection of therapeutic measures must be founded on a survey of the individual as a whole and must take into consideration heart and kidney function as well as the condition of the vessels themselves. It is coming to be pretty well recognized that medication alone is of little permanent value either in halting the advance of the arteriosclerosis or in averting the crises which are a part of its later symptomatology.

Dietetic treatment, such as the limitation of proteins and salt, care of the overloaded colon, limiting the amount of intensive mental work, avoidance of worry, and exercise in the open, each has its advocates, and each or, better, all combined have some value in combating the influences that further the progression of this disease.

In older persons with flabby muscles and low pressure, in whom compensatory factors are at a low ebb, there are a number of measures which, diligently attended to, may do much toward preventing these circulatory upsets in the central nervous system.

Of first importance is the avoidance of fatigue. Patients should be cautioned against carrying physical exertion to the point at which exhaustion is felt. Exercise or productive labor must be interrupted by frequent periods of rest. The short nap in a chair after meals is a protective measure, for the night sleep will then be less profound and the tendency to that extreme depression of the circulation which accompanies deep sleep will be obviated. Carefully selected food administered in frequent small feedings, rather then in larger meals, will prove of benefit. Animal proteins should be restricted.

The iodids seem to be of some value when given continuously over long periods. Strychnin in full doses, the last one of the day being administered at bedtime, has appeared to be useful in our cases.

On theoretical grounds it would seem that attention to the normal muscular support to the circulation of the lower half of the body would be of value, and in practice the beneficial effect of regulated exercises has amply justified their use. In fact, it is doubtful whether all other forms of treatment combined have the permanent value of systematic exercises especially directed to the development and maintenance of firm muscular support to the circulation of the lower limbs and abdomen.

The first exercises of the day should be performed before getting out of bed in order that, on assuming the vertical position, the splanchnic drop may be pre-

10. Birtch, F. W., and Inman, T. G.: Blood Pressure Observations on Patients with Relaxed Abdominal Musculature, J. A. M. A. 58:1 265-268 (Jan. 27) 1912.
11. Miller, J. L.: Hypertension and the Value of the Various Methods for Its Reduction, J. A. M. A. 54:1 1666 (May 21) 1910.

vented. Alternately raising the body and lower limbs by the action of the abdominal muscles will be sufficient for this purpose. Two or three times during the day the same exercises are to be repeated, with the addition of any of the various systematic "setting up" movements which may seem indicated in the particular case.

If it is a fact that degenerative conditions advance slowest where nutrition is best maintained, it is to be expected that pathologic changes in the cerebral vessels may in some degree also be retarded by an increase in the volume of the cerebral circulation, for with an increased flow in the vessels themselves will come additional nutriment by way of the vessels that supply them.

CONCLUSION

In the care of patients of advanced years we are likely to neglect the common hygienic measures frequently prescribed for the young, and it is with the hope that the too often neglected arteriosclerotics with hypotension may receive the attention they deserve that the foregoing suggestions as to their care are offered.

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PROPHYLAXIS OF SYPHILIS WITH ARSPHENAMIN

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We report a procedure for the prophylaxis of syphilis that has appealed to us as having especial value and, because of the paucity of its literature, as being worthy of publication.

The efficacy of calomel or other spirocheticides in the so-called chemical prophylaxis of syphilis is limited to a period of not more than eight hours after the spirochete has had the opportunity of invading the healthy person. In not every instance is it possible for the exposed person to reach competent medical aid for such treatment, and yet the possibility of infection is known to be very great. In other instances, the number of exposures may have extended over a period of several days, and the chemical prophylaxis is then known to be of little, if any, value. The difficulties of effective chemical prophylaxis in women is another factor that has brought some discussion as to the ultimate value of the procedure.

Recent work by Brown and Pearce[1] at the Rockefeller Institute for Medical Research adds to the evidence against the worth of chemical prophylaxis of syphilis as ordinarily understood. These authors studied the dissemination of spirochetes after inoculation into the scrotum and into the testicle of rabbits. They were able to demonstrate the organism in the regional lymph nodes within a period of less than forty-eight hours from the time of inoculation. They also found spirochetes in the blood stream prior to a period when the local lesion could be recognized at the point of inoculation. In addition, they removed the right scrotum and testicle in ten rabbits, forty-eight hours after inoculating the right scrotum with *Spirochaeta pallida*. In spite of the complete removal of a wide zone of tissue surrounding the area of inoculation, all these animals developed syphilitic lesions, thus showing that true infection of parts outside the zone of operation had taken place within the brief period of forty-eight hours.

Brown and Pearce conclude that:

> While the conditions of these experiments are not entirely analogous to those that obtain in cases of human infection, the general course of events is undoubtedly much the same in the two cases.
>
> It would appear, therefore, that, for practical purposes, there is probably no appreciable time during which a syphilitic infection can be regarded as confined to the focus of entry but that, immediately infection takes place, the spirochetes begin to multiply and invade the surrounding tissues, gaining access to both the lymphatics and the blood stream, and are widely distributed over the body even before the initial lesion can be detected.
>
> The early appearance of a distinctive lesion at the site of infection and the lapse of time required for the development of generalized lesions are to be viewed more as a result of a sequence in localization and concentration of spirochetes at given points than as indications of the time required for their dissemination.

Ehrlich, in proposing arsphenamin for the treatment of syphilis, had been led to believe by his experimental animal studies that one dose would rid the human patient of the disease by destroying all the spirochetes. More extensive use of the drug has proved the fallacy of "therapia sterilisans magna," because the drug as ordinarily administered is never in sufficient concentration to reach effectively every focus and nidus of the spirochete, once the organism has had the opportunity of disseminating itself by way of the lymphatics and blood stream to every part of the body. The treatment of syphilis in the early primary stage of the disease, when the patient presents a syphilitic chancre, a negative Wassermann reaction, and no adenopathy, is relatively simple and yet especially successful, as compared to the treatment of the same disease in the generalized secondary period. It is evident, therefore, that the earlier arsphenamin treatment is instituted, the more beneficial its effects will be.

The opportunity was granted one of us (G.) to use arsphenamin in the prophylaxis of syphilis while in the tropics, where a large proportion of the promiscuous women were affected with syphilis. At that time, he limited the use of the drug to men who had been exposed over twelve hours and frequently as long as three days previously. These men were given three doses of arsphenamin, a total of 0.9 gm., within forty-eight hours. Other patients were treated with arsphenamin who had lesions typical of the so-called soft sore or chancroid, in whom it was not possible to demonstrate the spirochete by the dark field. This group was treated with the idea of preventing the appearance of manifestations of a syphilitic infection which was still in its first incubation period. (The chancroid appears much sooner than the syphilitic chancre, though the two may have been contracted at the same exposure.) Most of these men were under observation only for a period long enough to determine that there was no chancre formed at the close of the ordinary period of incubation time of syphilis, or, in a few instances, as long as six months later.

One of us (M.) has for two years used the injections of neo-arsphenamin in the prophylaxis of syphilis as an occasional measure.

During the last six months, both of us have been more on the alert to use the method, and probably

1. Brown, W. H., and Pearce, Louise: A Note on the Dissemination of Spirochaeta Pallida from the Primary Focus of Infection, Arch. Dermat. & Syph. 2:470 (Oct.) 1920.

thirty patients have undergone the prophylatic treatment with arsphenamin. The patients that have been selected for this mode of prophylaxis have been, in the main, those in whom it was definitely possible to make a diagnosis of active syphilis in the opposing partner. This is a modification of the "diagnosis by confrontation" of the older writers in syphilis. For example, when the diagnosis of active syphilis is made, those likely to have been exposed to infection, usually the wife, and less often the husband, are examined. In the instances reported in this communication, they have been found free of lesions, but the possibility that they are in the primary incubation period of syphilis is so strong that, rather than wait for the appearance of symptoms clinically or serologically, arsphenamin injections are instituted.

The prophylactic doses have averaged 0.3 gm. of arsphenamin, and the number and interval of the injections have varied with the time since first exposure. In no case has this been less than three doses, and in only one case, now under observation, is it our intention to give six injections, as the patient's husband first came under observation with the generalized eruption of secondary syphilis, and a history of chancre for six weeks. It is our impression that the woman, in this instance, has come almost to the end of the incubation time of the disease, or even that she has passed that interval, and has a chancre which it is not possible to locate (syphilis d'emblée). It is our purpose to treat her as a Wassermann-negative primary syphilitic, and prevent the symptoms of the generalization of the disease.

We have not been consistent as to the interval of injections, varying from an injection every other day to once in five days, depending on the general physical condition of the patient. The women have been awarded the longer interval in the great majority of the cases.

The patients treated in this manner have been under observation long enough to state that the primary incubation time passes without the appearance of a primary lesion. No patient treated in this manner has developed a positive Wassermann reaction, although it has not been possible to repeat the tests in every patient.

We have found no reference in the English language to the use of arsphenamin or its substitutes in the prophylaxis of syphilis. Both the German and the French literature, however, have reports, several of which antedate any work on our part in this direction. No claim to priority is made, and we welcome additions to our bibliography.

The earliest suggestive reference we find is that of Stühmer.[2] He advocated the institution of specific therapy in cases of suspicious genital lesions, even if the modern diagnostic methods did not aid in establishing a positive diagnosis of syphilis. The possibility of thus destroying a focus for further syphilitic infections was thought to be of the utmost importance. The patient was, of course, kept under control by clinical and serologic observations.

Taege[3] goes farther than Stühmer, and proposes the use of arsphenamin during the incubation period of syphilis, when there are no lesions present, if exposure to a known case of syphilis is proved. This is the earliest communication on the subject of prophylaxis with arsphenamin that we have met. Taege used the technic recommended by Scholtz, and gave sodium arsphenamin for three doses within a period of twenty-four hours. Replying to Riecke,[4] who objected to the use of arsphenamin until the diagnosis of syphilis could be established, which he asserted was readily enough done in the chancre stage of the disease to institute the abortive cure, Taege[5] says that the early diagnosis of syphilis was not always feasible early enough to adopt abortive treatment. He maintained that this was especially true in women, for whom the prophylactic treatment was peculiarly adapted.

Fournier and Guenot[6] report on the abortion of syphilis by arsphenamin used during the incubation period. Forty women were exposed to infection by sexual congress with syphilitics having genital lesions. The men were all examined, and the presence of *Spirochaeta pallida* was demonstrated by the dark field. The Wassermann reaction was positive in all except five, who had had the chancre less than ten days. The period since exposure for the women was from a few days to three weeks. The women were free of all suspicious lesions, the history did not lead to the suspecting of a previous infection, and the Wassermann reaction was negative in all. Not one had exercised any preventive measures. Five women who refused all treatment, of the group that were similarly exposed, were later attacked by syphilis.

The forty women were treated by injections of arsphenamin (a total of from 1 to 1.20 gm.), of neo-arsphenamin (a total of from 1.2 to 2 gm.) or of an arsphenamin substitute. Not one of the forty ever showed any syphilitic lesion, and the Wassermann reactions of all have remained negative. Twenty of the women have been under observation over three years. One of the women, who after this treatment continued to receive her lover, who had mucous patches for which he did not take treatment, contracted a chancre of the face.

Lacapère and Laurent[7] are able to report four interesting observations on the preventive treatment of the syphilitic chancre:

Of three officers who had intercourse with one woman who presented a pigmentary syphilid, and numerous mucous patches of the mouth and vulva, two received a dose of neo-arsphenamin (amount not mentioned) intravenously and remained unscathed. The third preferred to take his chances with infection; he refused the injection, and after the usual incubation period, he presented the primary sore of syphilis.

The wife of an officer, who had connection with her despite his having a chancre and a positive Wassermann reaction, was given three injections of neo-arsphenamin, in doses of 1.5, 3, and 4.5 gm., at intervals of six days. She never presented any lesions, and her Wassermann reaction remained persistently negative.

A young man with erosive syphilitic lesions of the glans and prepuce had repeated contacts each night for fifteen days with a young woman who presented no lesion, no history of antecedent syphilis, and a negative Wassermann reaction. She was given eight injections (dosage not mentioned) of neo-arsphenamin, and she has remained free of lesions, and Wassermann negative.

A nursing heredosyphilitic had exposed two wetnurses to infection. One of the two later nursed another infant. About eleven days after the last nursing of the first infant she presented a lesion of the nipple, from which spirochetes were demonstrated by the dark field. The child she was then nursing was certainly not a heredosyphilitic, and the possibility of infection was certain. At intervals of five days, neo-

2. Stühmer, A.: Deutsch. med. Wchnschr. **44**: 41, 1918.
3. Taege: München. med. Wchnschr. **66**: 841, 1919.
4. Riecke: München. med. Wchnschr. **66**: 969, 1919.
5. Taege: München. med. Wchnschr. **66**: 1119, 1919.
6. Fournier, Louis, and Guenot, L.: Presse méd. **27**: 554 (Oct. 1) 1919.
7. Lacapère and Laurent: Bull. méd. **33**: 539, 1919.

arsphenamin, in doses of 10, 15, 20, 40 and 50 mg., was given intravenously. Eighty-five days after the last feeding from the affected breast, no lesions had appeared in the child.

As far as we can ascertain, there are no reports of the failure of arsphenamin to prevent syphilis, when injected during the incubation period of the disease. Theoretically there may be some objection, as Riecke advanced, against the procedure; but in practice the actual prevention of contact cases of syphilis from known cases overcomes any such adverse argument.[8]

SUMMARY

We have called attention to a method of preventing syphilis which we have found efficacious and which has not previously been described in the American literature. The injections of arsphenamin in small doses in persons who present no lesions, and who are definitely known to have been exposed to syphilitic infection, has in all the cases resulted successfully in acting as a prophylactic measure. The time since exposure has little bearing on the result, but must be taken into consideration when the minutiae of the procedure are under consideration. In two reported cases, a single injection has been held to be ample. In a patient under our own care, we intend to use a modification of the abortive cure, although she presents no lesions, because the date of first exposure is longer than the usual incubation time of syphilis. We shall at some future time report our cases in detail. That the method will encounter objection has already been proved; but it will continue to be a procedure that will fill its place in the prophylaxis of syphilis.

15 Central Park, West.

SALIGENIN AS A LOCAL ANESTHETIC FOR THE FEMALE URETHRA*

ARTHUR D. HIRSCHFELDER, M.D.
AND
H. M. N. WYNNE, M.D.
MINNEAPOLIS

Though poisoning from cocain absorbed from the genito-urinary tract is relatively rare, danger from this source is sufficiently imminent to warrant the introduction of less toxic local anesthetics. Hirschfelder, Lundholm and Norrgard [1] have introduced saligenin (salicyl alcohol, $C_6H_4.OH.CH_2OH$, 1:2) as a local anesthetic. It is about one fifth as toxic to mammals as procain, and about one fiftieth as toxic as cocain. Its low toxicity warranted us in testing it out clinically in cystoscopy in a series of twenty-six cases in the gynecologic outpatient service of the University of Minnesota and in the private practice of one of us (W.).

In all these cases, 2 c.c. of a 4 per cent. solution of saligenin was injected into the urethra, and a pledget of absorbent cotton soaked in the same solution placed over the external urethral meatus for five minutes. Several patients noticed a distinct stinging sensation immediately after the injection. A working anesthesia was obtained in every case, apparently as satisfactory as that produced by a 10 per cent. solution of cocain.

TABLE 1.—RESULTS IN OUTPATIENT SERVICE

Dispensary No.	Date	Age	Race	Diagnosis	Degree of Dilatation
3569*	11/28/19 12/ 5/19 12/19/19 1/ 2/20 1/16/20 1/25/20	46	White	Cystitis, general; pyelitis bilateral	Hegar No. 10
3861	11/29/19	21	Mexican Indian	Cystitis, ulcerative, acute	Hegar No. 8
2863	11/26/19	56	White	Cystitis, general; urethritis, chronic	Hegar No. 8
4046	12/12/19 6/ 4/20	41	White	Urethritis and trigonitis, chronic	Hegar No. 8 Hegar No. 8
4237*	12/19/19 1/ 9/20 1/16/20 1/23/20 3/ 5/20	30	White	Cystitis, general; pyelitis, left; pyonephrosis, right	Hegar No. 8 Hegar No. 9 Hegar No. 9 Hegar No. 9
5735	1/15/20	33	White	Urethritis, chronic	Hegar No. 8
0518	2/27/20 3/12/20	59	White	Urethritis, chronic	Hegar No. 10 Hegar No. 8
7134	3/ 5/20 3/22/20	38	White	Cystitis, general; urethritis, chronic	Hegar No. 10 Hegar No. 10
2179	3/ 5/20 3/26/20	38	White	Hydronephrosis, right	Hegar No. 10 Hegar No. 9
0928	3/12/20 6/ 4/20	22	Negro	Cystitis, ulcerative	Hegar No. 8 Hegar No. 9
6475	3/22/20	31	White	Urethritis, chronic	Hegar No. 8
6873	3/22/20	23	White	Urethritis, chronic	Hegar No. 8
4868	3/22/20	20	White	Urethritis, chronic	Hegar No. 10
3025	3/22/20	22	White	Urethritis, chronic	Hegar No. 8
5713	3/26/20	347	White	Urethritis, chronic	Hegar No. 8
8088	4/ 6/20	607	White	Urethritis, chronic	Hegar No. 10
9819	5/14/20	357	White	Urethritis, traumatic	Hegar No. 8
9738	5/14/20	45	White	Cystitis, general	Hegar No. 9
11101	6/15/20	34	White	Urethritis, chronic	Hegar No. 10

* Cocain, 10 per cent., had been used previously; patient stated that saligenin was equally satisfactory.

In a few cases we tried a 2 per cent. solution, but it was not satisfactory. In a few other cases a 6 per cent. solution was used. However, the 4 per cent. solution seems to be sufficient.

There is a great advantage in using this anesthetic of low toxicity, for a considerable quantity of the solution can be injected into the bladder after catheterization. This reduces the spasm so that a rapid and satisfactory examination can be made. Many of the patients had very sensitive urethras. Some of them had previously been anesthetized with cocain and stated that the saligenin anesthesia was as satisfactory as that obtained with cocain.

TABLE 2.—RESULTS IN PRIVATE PRACTICE

Name	Date	Age	Race	Diagnosis	Degree of Dilatation
Mrs. J. H.	12/ 6/19 12/20/19 1/ 6/20 1/17/20	32	White	Cystitis, mild	Hegar No. 10
Mrs. D.*	1/10/20 2/ 2/20 3/ 2/20	50	White	Stricture of urethra; eversion of urethral mucosa	Hegar No. 6 Hegar No. 9 Hegar No. 9
Mrs. M.	3/13/20	29	White	Urethritis, chronic; stricture of urethra, early	Hegar No. 7
Mrs. G.	3/18/20	31	White	Urethritis, chronic	Hegar No. 7
Miss H.	3/18/20	19	White	Urethritis, chronic	Hegar No. 7
Mrs. T.	4/ 4/20	25	White	Cystitis, chronic	Hegar No. 10
Mrs. C.	4/14/20	24	White	Cystitis, general; pyelitis, right	Hegar No. 9

* An unusually tender urethra; patient states that cocain, 10 per cent., is no better anesthetic.

A summary of the cases is given in the accompanying tables.

It would therefore appear that saligenin is a practical, nontoxic, local anesthetic which is distinctly useful in work on the female urethra and bladder.

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THE SURGICAL TREATMENT OF TYPHOID CARRIERS *

EDWIN HENES, JR., A.B., M.D.
MILWAUKEE

Recent work on the detection of chronic carriers of *Bacillus typhosus* has eliminated almost all of the "carriers" except those harboring the infection in the gallbladder and cystic duct. It is true that persistent "urinary" carriers have been encountered, and that their infectiousness can be cured by the removal of the offending kidney. "Kidney carriers" are exceedingly rare, and develop only when the kidney has been previously involved in some other pathologic process, such as pyonephrosis, hydronephrosis and nephrolithiasis, and on which the infection with *B. typhosus* is secondary. A kidney, otherwise normal, is incompatible with persistent urinary infectiousness of renal origin. A primary urinary carrier, that is, one having normal kidneys, would excrete typhoid bacilli from both kidneys. The fact that an infectious kidney is usually, if not invariably, an otherwise pathologic kidney, indicates that the urinary carrier state is a secondary one.

Apparently, with the gallbladder this is not so. The gallbladder or its contents is notoriously susceptible to infection in typhoid fever. Cholecystitis is a far more frequent complication during typhoid fever than is generally supposed. Post-typhoid cholecystitis, with or without stones, has been noted as occurring from one month even to twenty-one years after the original fever. Living typhoid bacilli have been obtained in cultures from the gallbladder as late as twenty-one years after the original infection. It is most probable that the cholecystitis that occurs in typhoid fever is due to *B. typhosus*, and gallstones are extremely prone to form in such an infected gallbladder. Although the complicating cholecystitis in typhoid fever is usually too mild to require surgical intervention, the fact that gallstones and a chronic cholecystitis are the usual sequelae of this complication makes it debatable whether the treatment should always be palliative, particularly as virtually all persistent carriers owe their infectiousness to an involved gallbladder. Moreover, certain of the relapses are attributed to reinfection from the gallbladder. All of these facts would suggest radical intervention in typhoid cholecystitis in spite of the systematic disease, because experience in intestinal perforation has proved that operations are not too forbidding.

In the summer of 1918, I was able to profit by an unusual opportunity to study typhoid fever, particularly in respect to complicating cholecystitis and continued infectiousness. One hundred and eighty-three patients who had contracted typhoid fever at the detention camp for interned alien enemy Germans at Hot Springs, N. C., were sent to U. S. Army General Hospital No. 12 at Biltmore, N. C., where I was on duty, for observation and treatment. The duodenal tube was being used at the hospital in the detection of gallbladder infections, and the Surgeon-General's Office urged systematic investigations of the problems involved in the continued infectiousness in typhoid fever. The careful and detailed studies that were made seem to justify these conclusions:

1. So-called "urinary" carriers are exceedingly rare, and when the condition does occur, preexisting pathologic lesions of one or both kidneys are responsible for the continued infectiousness of the urine.

2. So-called "intestinal" carriers, that is, those in whom cultures from the feces are persistently positive and repeated cultures from the duodenal contents are persistently negative, probably do not exist.

3. Persistent infectiousness from the bowel is directly attributable to an infected gallbladder.

4. All patients who have suffered from a complicating cholecystitis in the course of typhoid fever are to be carefully and repeatedly examined to determine continued infectiousness of gallbladder origin.

5. Nearly all patients with complicating cholecystitis (unless operated on early) will develop cholelithiasis.

6. Persons who continue to give positive duodenal or fecal cultures six months after the onset of the disease should be considered persistent carriers.

7. A positive duodenal culture of *B. typhosus* indicates infection from the feces, and the bacilli will invariably be found in the stool if the proper bacteriologic technic is employed.

8. Postoperative cultures from the gallbladder in patients who previously showed a positive duodenal culture will usually be positive for typhoid bacilli.

9. Cultures from recently formed stones (crushed) found in a gallbladder obtained from a person in whom a positive duodenal culture had been previously obtained will usually be positive for typhoid bacilli.

10. Biliary calculi usually form quickly (three months) after a complicating or post-typhoid cholecystitis.

REPORT OF CASES

The accompanying cases are presented to show the efficacy of the surgical treatment of typhoid carriers and to confirm the observations of Nichols, Simmons and Stimmel.[1]

CASE 1 (33).—A man, aged 31, taken ill, July 31, 1918, and admitted to General Hospital No. 12, August 14, had not received prophylactic antityphoid inoculations. Four blood cultures, taken August 26 and September 5, 11 and 22, were negative, but a positive Widal reaction was obtained, September 9. On the fifty-sixth day of the disease the temperature was normal, the illness having run a moderately severe course. No subjective symptoms referable to the gallbladder were complained of, and the past history gave no suggestion of previous gallbladder trouble.

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Cultures from urine	46 +	47 —	53 —	61 —		
Cultures from stool	46 —		53 —	61 —	213 —	
Cultures from duodenal contents	67 +	95 +	125 +	160 +	195 —	198 —

As will be noted (Table 1), the duodenal cultures continued positive until the one hundred and sixtieth day, and were negative thereafter. Two such negative duodenal cultures are not conclusive evidence of freedom from infectiousness unless the duodenal tube is permitted to stay in place for twelve hours or more and repeated aspirations and examinations are made. It is to be regretted that cultures of the stool were not taken between the sixty-first and the one hundred and sixtieth days; with the improved technic subsequently employed, typhoid bacilli would doubtlessly have been found in the feces.

It has been suggested that vaccines and alkalis be used therapeutically to clear up infectiousness. I do not believe such treatment especially efficacious: the majority of infected gallbladders clear up without treatment. Surgical intervention to clear up continued infectiousness is not to be resorted to sooner than six months after the onset of the disease. In the case

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As far as we can ascertain, there are no reports of the failure of arsphenamin to prevent syphilis, when injected during the incubation period of the disease. Theoretically there may be some objection, as Riecke advanced, against the procedure; but in practice the actual prevention of contact cases of syphilis from known cases overcomes any such adverse argument.[8]

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as a local anesthetic. It is about one fifth as toxic to mammals as procain, and about one fiftieth as toxic as cocain. Its low toxicity warranted us in testing it out clinically in cystoscopy in a series of twenty-six cases in the gynecologic outpatient service of the University of Minnesota and in the private practice of one of us (W.).

In all these cases, 2 c.c. of a 4 per cent. solution of saligenin was injected into the urethra, and a pledget of absorbent cotton soaked in the same solution placed over the external urethral meatus for five minutes. Several patients noticed a distinct stinging sensation immediately after the injection. A working anesthesia was obtained in every case, apparently as satisfactory as that produced by a 10 per cent. solution of cocain.

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6518	2/27/20 3/12/20	50	White	Urethritis, chronic	Hegar No. 8 Hegar No. 8
7154	3/ 5/20 3/22/20	38	White	Cystitis, general; urethritis, chronic	Hegar No. 10 Hegar No. 10
2179	3/ 5/20 3/26/20	38	White	Hydronephrosis, right	Hegar No. 10 Hegar No. 9
6928	3/12/20 6/ 4/20	22	Negro	Cystitis, ulcerative	Hegar No. 8 Hegar No. 9
6475	3/22/20	31	White	Urethritis, chronic	Hegar No. 8
6673	3/22/20	23	White	Urethritis, chronic	Hegar No. 8
4866	3/22/20	30	White	Urethritis, chronic	Hegar No. 10
3025	3/22/20	22	White	Urethritis, chronic	Hegar No. 8
5713	3/26/20	54?	White	Urethritis, chronic	Hegar No. 8
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In a few cases we tried a 2 per cent. solution, but it was not satisfactory. In a few other cases a 6 per cent. solution was used. However, the 4 per cent. solution seems to be sufficient.

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Cultures from urine	46 +;	47 —;	53 —;	61 —		
Cultures from stool	46 —;		53 —;	61 —;	213 —	
Cultures from duodenal contents	67 +;	95 +;	125 +;	160 +;	195 —;	198 —

As will be noted (Table 1), the duodenal cultures continued positive until the one hundred and sixtieth day, and were negative thereafter. Two such negative duodenal cultures are not conclusive evidence of freedom from infectiousness unless the duodenal tube is permitted to stay in place for twelve hours or more and repeated aspirations and examinations are made. It is to be regretted that cultures of the stool were not taken between the sixty-first and the one hundred and sixtieth days; with the improved technic subsequently employed, typhoid bacilli would doubtlessly have been found in the feces.

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under consideration it was, apparently, not necessary to perform a cholecystectomy.

Case 2 (53).—A man, aged 42, taken ill, August 4, and admitted to the army hospital, August 16, had not received antityphoid vaccination. The blood culture was negative, August 18, but the Widal reaction was positive, September 9. The disease ran a moderately severe course.

The patient developed an acute cholecystitis on the twenty-fifth day of the disease, and a cholecystectomy was performed on the forty-fifth day. It is my belief that the great majority

TABLE 2.—DAY OF DISEASE AND RESULT OF CULTURES IN CASE 2

Cultures from urine	25 +;	35 +;	46 —;	52 —;	58 —;	79 —	
Cultures from stool	25 —;	35 +;	46 —;	52 —;	58 —;	79 —	
Cultures from duodenal contents	66 —;	139 —;	146 —				

of cases of typhoid fever will show a positive duodenal culture at some stage of the disease; examinations made to determine gallbladder infectiousness are to be made soon after the febrile period of the disease. In this instance, the stool showed bacilli on the thirty-fifth day. The gallbladder was also infected during the disease because the cultures taken from the gallbladder at operation showed typhoid bacilli; positive cultures were also obtained from the stones that the gallbladder contained. Duodenal cultures taken on the sixty-sixth day (three weeks after the cholecystectomy) and on the one hundred and thirty-ninth and one hundred and forty-sixth days were negative, and these are proof that the cholecystectomy had cleared up the infectiousness.

TABLE 3.—DAY OF DISEASE AND RESULT OF CULTURES IN CASE 3

Cultures from urine	60 —;	66 +;	67 —;	72 —;	78 +;	85 —;		
	92 —;	99 —;	105 —;	112 —;	115 —;	123 —;		
	130 —;	143 —;	235 —;	240 —;	255 —;	278 —;		
	285 —;	304 —;	311 —;	316 —;	319 —			
Cultures from stool	60 —;	66 —;	67 —;	72 —;	78 —;	85 —;		
	92 —;	99 —;	105 —;	112 —;	115 —;	123 —;		
	140 —;	178 —;	240 +;	255 —;	278 —;	285 —;		
	304 —;	311 —;	316 —;	319 —				
Cultures from duodenal contents	92 +;	105 +;	106 +;	218 +;	221 +;	305 —;		
	312 —;	319 —						

Case 3 (57).—A man, aged 34, taken ill, July 27, and admitted to the army hospital, August 13, had not received prophylactic inoculation. The blood culture was negative, August 18, but was found to be positive, August 30, during a relapse. The Widal reaction was positive, August 30. The course of the disease was very severe, and normal temperature was reached on the sixty-eighth day.

The patient developed an acute cholecystitis on the ninety-fifth day, and a cholecystectomy was performed on the ninety-

TABLE 4.—DAY OF DISEASE AND RESULTS OF CULTURES IN CASE 4

Cultures from urine	57 —;	63 —;	89 —;	74 —;	86 —;	
	98 —;	100 —;	107 —;	119 +;	126 —;	
	133 —;	140 —;	150 —;	171 —		
Cultures from stool	57 —;	63 —;	60 —;	74 —;	86 —;	
	98 —;	100 —;	107 —;	119 —;	126 —;	
	133 —;		160 —;	170 —		
Cultures from duodenal contents	74 —					

seventh day. Previous to operation, typhoid bacilli were found in the duodenal contents, but repeated examinations of the stool failed to reveal the organisms until the two hundred and fortieth day. At operation, gallstones were found; and cultures from the gallbladder contents, bile and stones, were positive for typhoid bacilli. Despite the removal of the gallbladder, cultures of the duodenal contents continued positive until the two hundred and twenty-first day. On the three hundred and fifth day the cultures showed that the infectiousness had disappeared, for subsequent cultures of the stool and duodenal contents continued negative.

Case 4 (54).—A man, aged 48, taken ill, July 25, and admitted to the army hospital, August 13, had not received antityphoid inoculation. Blood cultures, taken August 18 and 30, September 20, October 12, November 21 and January 17 were all negative. The Widal reaction, however, was positive, August 30.

In this case it will be noted that typhoid bacilli were not found in either the stool or the duodenal contents. On the one hundred and nineteenth day after the onset of the disease a cholecystitis (and probably a relapse) developed; the patient never returned to complete convalescence, eventually developed influenza, and died of pneumonia on the one hundred and eighty-ninth day. It is of interest in this case that the patient had frequently complained of symptoms referable to the right upper abdomen, before an outspoken cholecystitis had manifested itself. It is to be regretted, also, that only one culture of the duodenal contents was taken. A postmortem examination revealed chronic cholecystitis; the contents of the gallbladder were positive for typhoid bacilli, and the stones it contained, when crushed, also showed typhoid bacilli.

The case just presented is exceedingly interesting. The cultural findings at necropsy are sufficient proof that additional examinations of the duodenal contents would have resulted in finding the bacilli, unless the cystic or common duct had become occluded. Furthermore, typhoid bacilli would most certainly have been found in the stool. It is necessary to emphasize the fact that the usual, routine examination of the stools for typhoid bacilli must be replaced by a careful technic in which a large amount of stool is emulsified and cultivated and at least six to ten plates poured. It has been our experience, gained toward the end of our studies, that a positive duodenal culture will precede the finding of the organisms in the stool, provided the proper technic is employed.

Case 5 (51).—A man, aged 27, taken ill, July 25, and admitted to the army hospital, August 14, had received one antityphoid inoculation, August 6. The blood culture was negative, August 19. The disease ran an uneventful course, normal temperature was reached on the forty-eighth day, and no symptoms referable to the gallbladder were complained of during the course of the disease.

TABLE 5.—DAY OF DISEASE AND RESULT OF CULTURES IN CASE 5

Cultures from urine	43 —;	49 +;	55 —;	61 —;	67 —;		
	165 —;	171 —;	181 —				
Cultures from stool	44 +;	50 +;		61 —;	66 —;		
	73 —;	99 +;	130 +;	161 +;	165 —;		
	171 —;	181 —;	187 —;	194 —			
Cultures from duodenal contents	78 +;	99 +;	130 +;	161 +;	194 —;		
	200 —;	203 +					

By the authority of the Surgeon-General's Office, this patient was subjected to a cholecystectomy to cure a persistent carrier. The operation was performed on the two hundred and thirty-sixth day, at which time a culture from the gallbladder and from the stones it contained were both positive for typhoid bacilli. This patient died three days after operation from a supposed intra-abdominal hemorrhage: a postmortem examination was not made.

Case 6 (48).—A man, aged 25, taken ill, July 21, and admitted to the army hospital, August 13, had not received prophylactic inoculation. The blood culture was negative, August 18 and 19, but the Widal reaction was positive, September 9. The disease ran an uneventful course and was of moderate severity, the temperature returning to normal on the thirty-eighth day. No symptoms referable to the gallbladder were complained of during the course of the disease.

This is another patient on whom a cholecystectomy was performed to cure persistent infectiousness. It is to be noted that the stool was found quite persistently positive for typhoid bacilli until the two hundred and twentieth day, while the

duodenal contents were found to be positive until the one hundred and sixty-seventh day, and presumably up to the time of operation. A cholecystectomy was performed on the two hundred and forty-sixth day, at which time the gallbladder contents and biliary calculi both showed typhoid bacilli. Subsequent cultural examinations were negative, and we have every reason to believe that the patient was cured of his carrier state.

At the time of operation, cultures from the stool were negative; while the last preoperative duodenal culture was positive (one hundred and sixty-seventh day). The last positive culture from the stool was obtained on the two hundred and twentieth day. It is to be presumed, therefore, that the duodenal contents were infectious up to that day, at least. It was decided to perform a cholecystectomy because typhoid bacilli had been previously found in the stool and duodenal contents so frequently and so persistently. Under the circumstances, we were justified in believing that the gallbladder was infected.

TABLE 6.—DAY OF DISEASE AND RESULT OF CULTURES IN CASE 6

Cultures from urine	51 —;	60 —;	66 —;	73 —;	81 —;
	89 —;	109 —;	175 —;	184 —;	220 —;
	241 —;	249 —;	264 —;	271 —;	290 —;
	297 —;	307 —;	305 —		
Cultures from stool	51 —;	60 —;	66 +;	73 —;	81 —;
	89 —;	163 +;	165 +;	169 +;	175 +;
	184 +;	191 +;	198 +;	205 +;	211 +;
	220 +;	226 —;	241 —;	264 —;	271 —;
	290 —;	298 —;	305 —		
Cultures from duodenal contents	66 +;	99 +;	134 +;	167 +;	291 +;
	298 —;	305 —			

It is to be admitted that an infected gallbladder does not necessarily imply a positive culture of the duodenal contents, especially in the event of the occlusion of the cystic duct. But I am of the opinion that a gallbladder, infected with living typhoid bacilli, and failing to drain into the duodenum because of occlusion of the cystic duct, will soon give trouble and direct attention to the gallbladder.

CASE 7 (50).—A man, aged 50, taken ill, August 2, and admitted to the army hospital, August 13, had received one antityphoid inoculation, August 1. The blood culture was negative, August 18. The disease ran a mild course, and normal temperature was reached on the twenty-third day. No symptoms of cholecystitis were manifest during the course of the disease.

In this case a cholecystectomy was performed on the two hundred and thirtieth day of the disease, infectiousness from the duodenal contents and therefore from the stool having been fairly consistent up to the time of operation. At operation, as in all the cases in this series, the contents of the gallbladder, and the stones it contained, were found positive for typhoid bacilli. It is of interest to note that, although subsequent examinations of the stool were negative for forty days after operation, the bacilli were, nevertheless, eventually found again on the two hundred and ninety-third day, while all postoperative cultural examinations of the duodenal contents continued positive for typhoid bacilli. Here, then, is a case in which a cholecystectomy did not cure the infectiousness. We had occasion in this case to perform another laparotomy to repair a ventral hernia. At the second operation, the site of the original operation was carefully explored and an attempt made to isolate and puncture the hepatic duct. But the original field of operation was matted down with adhesions, and the surgeon deemed it unwise to continue the exploration. This patient was transferred to another hospital when General Hospital No. 12 closed, Sept. 1, 1919.

TABLE 7.—DAY OF DISEASE AND RESULT OF CULTURES IN CASE 7

Cultures from urine	40 +;	43 —;	59 —;	69 —;	71 —;	
	151 —;	153 —;	163 —;	172 —;	210 —;	
	229 —;	231 —;	245 —;	256 —;	259 —;	
	278 —;	285 —;	290 —;	295 —		
Cultures from stool	15 —;	40 —;	43 +;	52 +;	71 +;	
	78 +;	86 +;	92 +;	100 —;	107 +;	
	114 —;	121 +;	129 +;	136 +;	144 +;	
	152 +;	160 +;	172 +;	179 —;	186 +;	
	193 +;	199 +;	206 +;	214 +;	245 —;	
	250 —;	278 —;	285 —;	290 +;	295 +;	
Cultures from duodenal contents	44 +;	66 +;	122 +;	152 +;	160 +;	
	186 +;	279 +;	286 +;	293 +;		

COMMENT

Apparently the majority of persistent typhoid carriers (and I believe all) can be cured of infectiousness by the removal of the gallbladder. The detection of carriers is of paramount importance. It must be taken for granted that in all cases of typhoid fever the gallbladder may be involved. Cultural examinations of the duodenal contents are absolutely indicated in all patients convalescent from typhoid fever, and these bacteriologic examinations are far more important in detecting continued infectiousness than are those of the stool.

Irregularities and inconsistencies in the cultural findings of the duodenal contents indicate that at least three consecutive, negative examinations, at intervals of a week, are to be obtained before a chronic carrier can safely be dismissed. Our studies at Biltmore prove that the positive and negative results may be obtained at one examination if the duodenal tube remains in place for twelve hours or more, and aspirations and cultural examinations are made every two hours. It has been shown that not all specimens obtained during the twelve hour period from a duodenum, when the gallbladder is known to be infected, will show typhoid bacilli. No chronic carrier, with or without a cholecystectomy, should be given his freedom on the basis of two consecutive, negative cultures of the duodenal contents. There can be no possible objection to permitting the duodenal tube to remain in place for twenty-four hours in order to allow for the intermittent emptying of the gallbladder. Periodic cultural examinations of the duodenal contents during a whole day will give much more accurate and dependable results, and will the more definitely establish the fact of cure of infectiousness. Three such negative examinations made at weekly intervals should be regarded as the criterion of a cure.

CONCLUSIONS

1. Cultural examinations of the duodenal contents are indicated in all cases during convalescence from typhoid fever.

2. Cholecystitis is a frequent complication of typhoid fever.

3. Persistent infectiousness following typhoid fever is usually the result of cholecystitis.

4. A gallbladder may continue to be infectious without the usual manifestations of a cholecystitis.

5. Cholecystectomy, with complete excision of the cystic duct, will cure the great majority of typhoid carriers.

6. Radical (surgical) treatment of complicating cholecystitis is to be considered. The likelihood of a carrier state is thereby greatly diminished, and the probability of future gallbladder trouble obviated.

7. Examination of the duodenal contents should imply an examination of the contents periodically aspirated and cultivated during the course of twelve or twenty-four hours. Three such consecutive, negative

NOTE.—I have been informed by the Surgeon-General that this patient, who had continued infectious long after the removal of the gallbladder, and who was transferred to General Hospital No. 6, at Fort McPherson, Ga., when General Hospital No. 12 was closed, was discharged and allowed his freedom, Nov. 18, 1919, apparently free from infectiousness. The Surgeon-General failed to state how freedom from infectiousness was determined. I had asked him to do so.

examinations, made at weekly intervals, are the criterion of a cure of persistent infectiousness.

8. Typhoid fever is a preventable disease. The incidence of the disease has been astoundingly decreased by the use of prophylactic inoculation, and more can be accomplished along these lines. But endemic typhoid will continue to exist just so long as we fail to detect persistent infectiousness. Our researches at Biltmore show conclusively that the gallbladder is the seat of continued infectiousness, and an intelligent cultural examination of the duodenal contents can definitely detect this infectiousness. No case of typhoid fever is to be judged free from infectiousness until it can be conclusively shown that the gallbladder and its contents are free from typhoid bacilli. In the event of persistent infectiousness, the indication is definite and absolute—cholecystectomy.[2]

445 Milwaukee Street.

SOLITARY AMEBIC ABSCESS OF THE LIVER

REPORT OF A CASE OCCURRING THIRTY YEARS AFTER RESIDENCE IN THE TROPICS

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REPORT OF CASE

A civil engineer, aged 53, who was referred by Dr. Edward Hiram Reede and who for many years was a resident of Canada, of good family history and moderate habits, at the age of 17 had had a left sided pneumonia and, at the age of 22, while resident in Central America, suffered from an attack which he described as "diarrhea" and not dysentery. This was not severe or of long duration, and thereafter his health remained good till May, 1919, when he had a mild febrile attack which was supposed at that time to be malaria.

Dec. 15, 1919, after a brisk walk, he felt sick and had a fever ranging from 101 to 102. With intermissions of about ten days of well-being, the malaise and slight fever continued till February, 1920. At that time, after a roentgen-ray examination, several abscessed teeth were extracted; February 6, diseased tonsils were removed.

There was some improvement, but mild fever of irregular, remittent type continued. A Widal test and a Wassermann test of the blood, examination of the sputum, roentgen-ray examination of the digestive tract, analysis of the gastric contents, and examination of the genito-urinary tract were made, with negative results.

When first seen by me, March 22, 1920, the patient complained of discomfort in the epigastrium beginning immediately after dinner and continuing with increasing severity till midnight or 3 o'clock in the morning. Occasionally there was slight pain between the scapulae, and once or twice bile was vomited, but no food. The patient had lost 20 pounds in weight in the last three months; the pulse was 92; the temperature was of irregular, remittent type, reaching 99.5 or 101.5 at some time in the afternoon or evening. There were no rigors or sweats. The leukocyte count was 10,000.

The first impression was that the subjective symptoms were due to some secondary focal infection following the known previous involvement of teeth and tonsils. The patient was therefore placed on such hygienic, dietetic and medicinal treatment as would alleviate the symptoms, increase nutrition, and improve the secondary anemia that was present, while an attempt was made to locate and determine the character of the infection.

Reexamination of the gastric contents, feces, blood, urine, and another roentgen-ray study of the gallbladder and duodenal region elicited no additional information of value; but on physical examination there could be demonstrated by percussion an increased area of dulness over the gallbladder. As the temperature rose a little higher, to 102.5, and the leukocyte count increased to 13,000, a tentative diagnosis of pus in or near the gallbladder was made, and Dr. C. S. White operated.

The enlarged and distended gallbladder contained normal bile; there were no stones or adhesions. On palpation of the liver there was found on the superior, anterior surface a soft area surrounded by slight induration, but no bulging or tumor. The characteristic chocolate-colored material was aspirated, and the abscess later treated surgically.

The pus was examined by two pathologists, but no amebas were found, and on culture no growth was obtained. After operation, emetin hydrochlorid was given hypodermically, the patient's appetite returned, the anemia improved, and there was a rapid gain in weight, with prompt and complete recovery.

COMMENT

In this case, presenting malaise, loss of weight, pain in the epigastrium, an intermittent fever of long duration, secondary anemia and moderate leukocytosis, the problem was to locate and determine the character of an infection. Clinicians emphasize the importance of tuberculosis, typhoid fever and syphilis as three common causes of fever of long duration. To these, in considering such a case as this, must be added septic endocarditis, hepatic intermittent fever of Charcot, pyelitis, certain types of malaria, neoplasm with typhoid symptoms, and abscess of the liver. By means of physical examination and laboratory tests, all of these could be excluded except tuberculosis, neoplasm, Charcot's fever and liver abscess.

On the usual clinical considerations it seemed that if tuberculosis and neoplasm could not be excluded they could be considered very improbable. The history of diarrhea while in the tropics was repeatedly reverted to, and an attempt was made to elicit evidence of recurrent dysentery, the feces were repeatedly examined for amebas, and the liver was examined for signs of enlargement or tenderness; but it was not until the patient had been under observation for fifteen days, and at least two months after the onset, that moderate tenderness and increase in the area of dulness over the gallbladder indicated the location of a lesion with sufficient definiteness to warrant an exploration.

Usually, abscess of the liver, as it occurs in the tropics, presents such signs and symptoms that diagnosis is simple and easy.

CONCLUSIONS

The foregoing case is reported for the purpose of giving emphasis to these not yet sufficiently recognized facts:

1. Amebic dysentery, and therefore amebic abscess of the liver, may occur in persons who have never been in tropical or subtropical countries.

2. Amebic abscess of the liver occasionally occurs a great many years after the primary and single attack of amebic dysentery.

3. Amebic abscess of the liver should be remembered as a cause of obscure fevers; for, as Dr. Richard P. Strong wrote, "Liver abscess is frequently overlooked, and this is not strange, for sometimes its development takes place so insidiously that perforation may be the first indication. . . . In the diagnosis of liver abscess there is not a single symptom that is constant, and proof that the liver is involved may be very doubtful."

1720 Connecticut Avenue.

2. Henes, Edwin, Jr.: Studies in Typhoid Fever, Wisconsin M. J., to be published.

AN EXTRAORDINARY CASE OF SITUS INVERSUS VISCERUM TOTALIS

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An approximately full term fetus was selected from the dissecting room material for the purpose of studying the arteries of the colon. A simple abdominal incision was made to approach the inferior mesenteric artery. As no descending colon on the left side was found, further dissection was made, with the result that not only the abdominal viscera but the thoracic structures as well showed a remarkable reversion and anomalous development.

HISTORICAL

Karashima,[1] in 1912, described a case of situs inversus totalis, and also gave a catalogue of such cases up to his time. His catalogue began with Aristotle, who mentioned two cases of reversal of the liver and spleen in animals. Fabricius, in 1600, related a case of reversed liver and spleen. Frochel, in 1745, made brief citation of partial inversion of abdominal viscera in a wider discussion on general malformations of the viscera. Cornelius Gemma of Antwerp, in 1769, was the first to make special study of such cases. Küchenmeister, in 1824, was the first to discuss such cases after examination by auscultation and percussion. Gruber, in 1865, catalogued sixty-seven cases in man and one in the horse. F. Küchenmeister, in 1883, was able to catalogue 149 cases, forty of which appeared before 1819, the year of the discovery of auscultation. Schelens, in 1909, found, since 1883, sixty new cases in the literature. Up to Karashima's time, 1912, something more than 200 cases had been catalogued. According to this author, cases of partial situs inversus are more rare than those of total inversion. This seems illogical in the light of other findings; however, he cites only twenty-two such instances that had been gathered. Eddy,[2] in 1912, described a case of arrested development of the pancreas and intestine which was evidently not included in Karashima's list. Naguchi,[3] in 1912, described an interesting case of unrotated intestinal tube in a new-born infant, in connection with other malformations. Deselaers,[4] in 1912, described a case of situs inversus totalis in which was found, in addition to reversion, a number of malformations. Cases are not wanting of total or partial reversion, found in the dissecting room or at necropsy, which are not on record, and it is felt that Karashima's percentage of partial and total cases would be different if records of all cases were carefully kept. After investigating the literature cited, I feel that the present case is sufficiently unique to be presented.

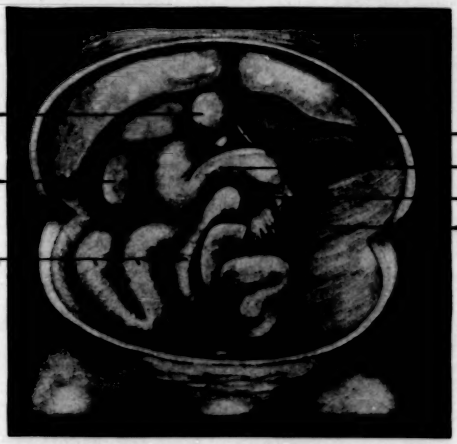

Fig. 1.—Anterior abdominal wall cut away, exposing the viscera in place; the small intestine has been removed; *C*, coils of the colon; *D*, common bile duct and cystic artery; *G*, gallbladder; *M*, mesentery; *P*, pancreas; *S*, spleen; *St*, stomach.

DESCRIPTION

The specimen, a near term female fetus, was selected from the dissecting material at the University of Chicago, for the purpose of making a special study of the arteries of the colon. Its chief value was its well developed state and good preservation. No data could be found of its history; but its weight, at the time of study, was 3,000 gm., and all general outward appearances were good. As the dissecting progressed it became more and more evident that here was a case of situs inversus of a remarkable type, not paralleled by any in the available literature. Not only is reversion encountered, but several instances of striking abnormalities appear, a greater number of anomalies, indeed, than can be found in recorded cases. There was a strong desire to go into a detailed discussion of these anomalies, but it seemed best to merely present a general report of the case.

Neck.—The structures in the neck of main interest are the arteries, which are abnormal in their origin from the arch of the aorta. As will be discussed later, the aorta is exactly reversed in position throughout its entire course. The first of its branches is the left common carotid artery, the next, the right common carotid, the third, the right subclavian, and the fourth, the left subclavian.

Here is a case of reversion of an abnormality. Cases are not rare in which the right subclavian artery arises from the arch of the aorta as a separate branch, the fourth, and crossing behind the esophagus, passes to the right arm. This anomaly arises from a readjustment of the embryonic aortae and their arches. The fourth arch on the right side normally forms the first part of the subclavian and, with the subclavian branch, it eventually forms the brachial. The part of the right dorsal aorta between the subclavian branch and the junction of the two aortae normally degenerates. In the anomaly, the arch degenerates and the aorta persists, and by unequal growth its point of attachment to the fully formed aorta comes to lie on the left side of the midline as the fourth aortic branch. In the present case this readjustment occurred, but exactly in reverse position (Fig. 2 *A* 1, 2, 3, 4). The veins of the neck are normal but for being reversed.

Thorax.—There is complete reversion of the viscera of the thorax. The descending vena cava lies on the left side of the

1. Karashima, I.: Ein Fall von Situs inversus viscerum totalis, Inaug. Diss., München., 1912.
2. Eddy, N. B.: A Case of Arrested Development of the Pancreas and Intestine, Anat. Rec. **6**: 299 (No. 8) 1912.
3. Naguchi, Y.: Ein Beitrag zur Pathologie des kongenitalen partiellen Darmdefektes, Virchows Arch. f. path. Anat. **209-210**: 220, 1912.
4. Deselaers, Hubert: Anatomische Untersuchung eines Falles von Situs viscerum inversus totalis, Inaug. Diss., Strasbourg, 1912.

median line and is formed by the union of the innominate veins, in reversed position. It is joined by the azygos vein after this vessel arches over the root of the left lung. The formation of the azygos vein is essentially that of a normal vein except for being reversed. It should be noted here, however, that the left first intercostal vein empties into the

Fig. 2.—Here the heart has been removed, exposing the posterior wall of the pericardium and the large blood vessels; the lower portion shows the stomach and its related structures more in detail: *A*, aorta; 1, left common carotid artery; 2 right common carotid artery; 3, right subclavian artery; 4, left subclavian artery.

azygos vein instead of the innominate. The lungs show an absence of clefts, dividing them into the typical lobes; but the roots show the characteristics typical of the two sides. The left root has the eparterial bronchus which normally belongs to the right side, and although there are no distinct lobes, three are indicated on the left side, by the bronchial divisions, and two on the right side. The lung substance, while appearing spongy, would not float.

Heart.—The heart shows remarkable abnormalities. It is completely reversed, and in addition shows several anomalies, being in an early embryonic state of development (Fig. 4). It has a flattened cone shape with the apex of the cone formed by the aortopulmonary trunk, and has its base flattened against the diaphragm. Two indistinct apexes are seen on the surface, in a bilateral position, with a broad, shallow depression between them. The pulmonary artery leaves the ventricles directly behind the aorta. This vessel in turn has the anterior position and passes by a sharp arch, to the right of the vertebral column, along which it descends, obliquely, till it passes into the abdomen directly in front of the column. From its arch it gives off its carotid and subclavian branches, as noted above. The sinus venosus and the two venae cavae lie on the left side, the superior vena cava being organized as formerly mentioned. The inferior vena cava passes through the diaphragm a little to the left and in front of the aortic opening. The atrium lies directly behind the ventricle and is entered by three short pulmonary veins (Fig. 2 *P. V.*). The interior of the heart shows the most striking anomalies. The primary foramen ovale and secondary foramen ovale are both present. There is only one ventricular cavity, no sign of an interventricular septum being present. The cavity is entered from the atrium through the atrioventricular foramen, which is guarded by a typical arrangement of bicuspid valves. There is no other opening into the ventricle, such as exists in a later state of development, when the ventricles become separated by the interventricular septum. The exit from the ventricle is into the aortopulmonary trunk, guarded by the typical group of valves. Fischer[5] in 1912, reported the case of a man, aged 21, who died of renal abscess following angina. At necropsy the heart was found to be quite similar to the present case, having only one ventricle discharging the blood into an aorta and a pulmonary artery.

There is here very clear evidence of an early embryonic heart functioning adequately in late fetal life. It is essentially a simple tube twisted into a single loop, terminating in an aorta and a pulmonary artery. The blood flow was through the vena cava into the sinus, then into the atrium, then into the ventricle and finally into the lungs through the pulmonary artery and into the systemic vessels through the aorta. The ductus arteriosis is present and functioning; indeed, it is a rather large structure. There is evidence of a free pulmonary circulation, since this artery is quite as well developed as the aorta, and clotted blood may be found in the pulmonary veins well into the lung region. What would have been the outcome had this individual lived, if indeed it could have lived with such a cardiac condition, is wholly a matter of speculation. It is noteworthy, however, that the fetus is well formed, there being no evidence, with a few exceptions, of retarded development. The state of development here is entirely compatible with such a heart, since the maternal circulation would compensate for any cardiac abnormality. As to the possibility of postnatal life for this individual, unpromising as it would seem, it must still be remembered that cases are not wanting in which the foramen ovale remained open even into adult life. I recall two such cases coming under my original observation, wherein the foramen had a diameter of some 15 mm. Fischer's case of a single ventricular cavity, functioning successfully in an adult, is a valuable contribution to a favorable prognosis for such a case as this. The abdominal aorta terminates in two unequal common iliac arteries; the right is the larger. The renal arteries are also unequal in size; here again the right artery is the larger.

Thoracic Wall.—The thoracic wall on the left side presents a very striking anomaly. The vertebral column is markedly scoliotic in this region, and there are only nine ribs on this side. Four of these have attachment to the sternum by cartilage; and the last, the ninth, is only rudimentary. The first is normal, but the second and third show marked variations from the normal. The second does not reach the ster-

Fig. 3.—First portion of the duodenum, split to show its connection with the pancreas: *D*, opening of the common bile duct; *P*, opening of the two pancreatic ducts.

num, but ends freely in the interval between the first and third, being only about one third as long as the normal (Fig. 5). A peculiar formation is seen at the bases of the second and third, in the form of two cross connections or arches passing between them. The smaller, which, in reality, is an intimate part of the bodies of the vertebrae, lies nearer the vertebrae and on a plane anterior to the second. It forms two loops, in a cephalocaudal position, which encircle the

5. Fischer, B.: Demonstration, situs inversus totalis, München. med. Wchnschr. 59: 555, 1912.

intercostal vessels. The second, which lies posterolaterad to the first and posterior to the intercostal structures, is the larger of the two and unites the two ribs proper. The first intercostal artery can be seen distributing branches to the first and second spaces, and in like manner the first intercostal vein receives a tributary from the second space also. Furthermore, the second space has two additional veins and an artery (Fig. 5).

Abdomen.—The liver attracts more than passing attention, as it is strictly normal and occupies its proper side. This is noteworthy; for here, where there is so complete reversion,

Fig. 4.—Heart seen from almost a straight cephalic view: *A*, atrium; *CA*, coronary artery; *P*, pulmonary veins; *Pc*, pericardium, line of attachment; *S*, sinus venosus; *V*, ventricle.

the one structure which is most commonly reversed remains unchanged. The two cases recorded by Aristotle showed reversion of the liver and spleen only. Many of the citations in subsequent literature have mainly this organ in mind. I again recall six cases of original observation in which the liver was the only structure reversed. The strictly normal state of the liver here lends added interest to the case.

Stomach.—The stomach has its typical shape and size, but lies on the right side, under cover of the liver (Fig. 1). The lesser curvature faces the midline; the greater curvature and fundus come into contact with the right lobe of the liver and make an impression on its under surface. The pylorus lies on the left side about 10 mm. from the midline. The cardia lies on the right side, where the esophagus passes through the diaphragm, to the right and slightly posterior to the passage of the vena cava. The lesser omentum and its structures present very striking anomalies. The ligament, which normally passes from the stomach to the liver, passes to the vertebral wall instead. The hepatic artery arises from the celiac axis and goes directly to the portal fissure. In its course it is accompanied by the portal vein, lying at first to its left and then passing in front of the vein at their entry into the liver. The common bile duct has a separate and isolated course. The hepatic and cystic ducts unite near the gallbladder, and the common duct then passes straight to the pyloric end of the stomach. In its course it is removed from the two vessels by about 10 mm. distance, the interval being filled by a pedunculated nodule of liver, attached to the processus caudatus. The cystic artery reaches the gallbladder by way of the duct. The duct enters the duodenum, on the posterior side, just distal to the junction of this structure and the pylorus (Fig. 1).

Pancreas.—This gland lies in close relationship to the pylorus and greater curvature of the stomach. What would otherwise be its head is very indistinct, since this part of the structure is intimately incorporated in the duodenal wall. This brings about the phenomenon of the two pancreatic ducts entering the duodenal canal separately (Fig. 3). The pancreatic artery arises directly from the abdominal aorta.

Spleen.—The spleen lies on the right side, between the liver and the stomach. It is somewhat elongated, resembling the pig spleen, but is otherwise normal (Fig. 1).

Intestines.—There is lack of rotation here as well as reversion. The small intestine shares the subphrenic fossa with the left lobe of the liver and kidney, and fills the remaining abdominal cavity on the left side. The colon occupies the portion of the right abdominal cavity not taken by the liver, stomach and spleen. There are no typical ascending and transverse portions of this tube. These are represented by a number of coils occupying the midplain position, where also may be seen the cecum and the appendix (Fig. 1). A very delicate membrane, the great omentum, could be identified stretching across from the greater curvature of the stomach to the coils of the colon. The descending colon and sigmoid have the normal characteristics, but for reversion. The mesentery is attached to the vertebral wall in an almost straight midplain line. It suspends the first portion of the colon as well as the small intestine.

Kidneys.—Both kidneys show the fetal lobulations, the left more distinctly than the right. In addition, it is much smaller than the right; its artery is also much smaller than is the right renal artery.

Genitalia.—The external genitals are normal in every way, as is also the vagina. The uterus, however, shows only the right tube and ovary. The body of the uterus is normal in shape and occupies its normal position, but the left tube is present only as a rudimentary cord, which is attached laterally to the rim of the pelvis. The left ovary is entirely wanting, and the right fimbria and ovary are smaller than the normal and lie within the abdominal cavity.

CONCLUSIONS

This case is interesting because of its great number of anomalies. Some are anomalies in reversion, as seen in the instances of the heart and aortic branches. In this connection, of especial interest is the fully developed body served by a heart of an early embryonic state. The real value, however, of this case lies in the positive data it offers to the problem of placing the causative factor for such anomalies. In his summary, Karashima offers two possible causes for inversion. One is that trauma, from various sources, in late

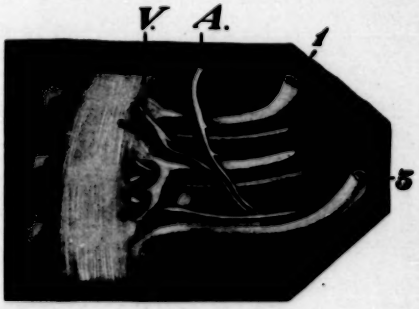

Fig. 5.—Portion of vertebral column; first, second and third vertebrae, showing scoliosis and deformities: *A*, superior intercostal artery; *V*, superior intercostal vein; 1, first rib; 3, third rib; the second rib is seen ending freely between the two.

embryonic life, may cause malformations. This might easily explain external deformity, and some kinds of internal derangments, but it is difficult to see its effect on reversion. Nor would Mall's [6] expression of "dissociation" and his enunciation that "it is perfectly

6. Mall, F. P.: On the Frequency of Localized Anomalies in Human Embryos and Infants at Birth, Am. J. Anat. 22:49 (July) 1917.

clear that monsters are not due to germinal and hereditary causes, but are products from normal embryos by influences which are to be sought in their environment" be applicable here. More to the point is the term, used by many, "cytoplasmic variation," in which it is suggested that in the germ cell there is a predilection for the ultimate form of the body, which at least influences these malformations. The expression leaves the problem practically untouched, except that it tranfers its consideration to an early period in development. The present case offers proof, as instanced by the reversed anomalous aortic branches, the primitive heart, the reversed root of the lungs and azygos veins, the relationship of the pancreas and the unrotated intestines, that these anomalies have their causative factor operating at a very early embryonic period.

NOTE.—The specimen is the property of the department of anatomy of the University of Chicago, where it remains and may be seen.

INTERVENTRICULAR CARDIAC ANEURYSM WITH HEART BLOCK *

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AND
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While aneurysms of different parts of the heart have been reported many times in the literature, their occurrence is much less frequent than in the aorta. The left ventricular wall near the apex is the most common site, 144 out of 147 cases in Bourland's [1] analysis of cases, although sacs filled with blood and communicating with the cavities of the heart have also been reported in the auricles and in the interventricular septum, as well as sacs formed from dilated valve leaflets. An aneurysmal dilatation may form whenever the elasticity of the wall is lessened, as in the fibrosis of interstitial myocarditis, in fatty degeneration, or where the wall is injured from new growths, gummas or disturbed circulation, whether syphilitic or not.[2] As with the aortic aneurysms, the cardiac variety may be a bulging of the entire thickness of a wall or the septum [3] or a valve leaflet, or the sac may result from dissection of the layers of the region itself. Of the 135 cases referred to by Osler,[4] 102 were in men.

There are no typical symptoms or signs, and diagnosis is usually made at necropsy. The area of relative cardiac dulness may be enlarged, but often the other lesions present may be of such a nature that enlargement may be otherwise explained if an aneurysm is not suspected. A marked discrepancy between the large size of the heart, the force and wide area of the impulses, and the small size of both radial pulses may suggest a cardiac aneurysm. There are no characteristic murmurs, and the blood pressure is not distinctive. There are apparently no references to changes in the electrocardiogram. The varying positions sometimes give signs characteristic of mechanical interference with the function of the part involved, such as murmurs from distorted valves or abnormal pulsations from unusual parts coming in contact with the chest wall, with dyspnea, cough and precordial pain from the disturbed function. Both acute and chronic cases have been reported, some as the result of trauma, others as the result of slower pathologic degenerative processes.

An unusual case of aneurysm in the interventricular septum of the heart, with associated heart block, was observed in the medical wards of the Cincinnati General Hospital.

REPORT OF CASE

History.—A colored man (E 4407), aged 36, was brought to the hospital complaining of "shortness of breath and swelling of the legs." During the last two years the patient had had difficulty in breathing, with hemoptysis after coughing, and precordial pain during the last year. About nine months before, while working as a railroad laborer, he found it so difficult to breathe that he had to stop work and rest for awhile before he could go ahead. Vertigo and headache came on with exertion, and the frequency of the attacks increased. He managed to continue working for about four months longer, when he had to stop work and go to bed. His physician was unable to relieve him. This was about five months before his admission to the hospital.

The patient had measles, mumps and whooping cough during childhood, and a syphilitic infection eight years before admission. He was a moderate drinker, and smoked about one package of cigarets a day. His father and mother died at 70 and 60 years of age, respectively, of "dropsy."

Examination.—The patient was well developed and well nourished. He sat upright with a back-rest at about 90 degrees most of the time. Breathing was rapid and somewhat shallow, about once to each two beats of the heart. The heart rate was 54 on admission. The patient had a harsh, irritating cough and profuse, bloody sputum. The head showed no lesions of note. The pupils were equal, small and reacted, but not perfectly, to light. There was no nystagmus.

The right ear drum was perforated, and there was a slight discharge. The nasal mucosa was injected. There was a slight congestion of the throat and tonsils, and the tongue was heavily and unevenly coated. The teeth were in fairly good condition. A marked pulsation was noted in the neck along the carotids.

The chest was well developed and symmetrical, and the nourishment was good. There was slight myotactic irritability. There was impairment over the left side of the chest in the base, anteriorly, but the rest of the chest appeared clear to percussion. The relative cardiac dulness and retrosternal dulness were:

First	interspace:	3 cm. to right,	4 cm. to left
Second	interspace:	3 cm. to right,	5 cm. to left
Third	interspace:	4 cm. to right,	8 cm. to left
Fourth	interspace:	5 cm. to right,	10 cm. to left
Fifth	interspace:		13 cm. to left
Sixth	interspace:		12 cm. to left

The apex beat was not visible, but was palpable 11 cm. to the left of the midline in the sixth interspace. A blowing systolic and a diastolic murmur were heard over the apex, aortic and pulmonary valve areas. The sounds were rather distant over the apex, with an occasional arrhythmia.

Over the base of the left lung, anteriorly, the sounds were almost suppressed, but higher up crackling râles were heard during inspiration, with the sounds harsh in the apex. On the right side inspiration was harsh and sonorous, while expiration was marked by fine, moist râles. Dry, crackling râles marked inspiration posteriorly.

The abdomen was about on the chest wall level. There was tenderness over the liver and epigastrium, and in the subcostal areas posteriorly. The liver edge was palpable about 4 cm. below the lower costal border in the midclavicular line. There was no evidence of much increase in fluid in the abdomen. No rigidity or masses were noted. There was hard edema of both legs, from the knees down.

Clinical Course.—On the following day the apex was palpated 14 cm. to the left of the midline, in the sixth interspace,

* From the University of Cincinnati College of Medicine and the Cincinnati General Hospital.

1. Bourland: Aneurysm of the Heart, Am. J. Med. Sc. 128:323, 1904.
2. Woolley, P. D.: Cardiac Aneurysms, J. Lab. & Clin. Med. 2:223 (Jan.) 1917.
3. Delafield and Prudden: Text Book of Pathology, Ed. 8, New York, 1907, p. 482.
4. Osler and McCrae: Modern Medicine, Ed. 2, Philadelphia, 1915, 4:482.

and the relative cardiac dulness was 4 cm. to the right in the fourth space, and 15.5 cm. to the left in fifth space. There was no thrill or abnormal shock. At the apex, a diastolic murmur was heard, which was most intense over the midsternum. The murmur replaced the second sound at the aortic area. On holding the breath, a faint systolic murmur was heard at the apex. There was no arrhythmia. The radial pulse (64) was very compressible, and there was no pulse deficit. A venous pulse of 100 was noted in the neck. Systolic pressure was 138; diastolic, 60.

At this time, a small area of impaired resonance (about the size of the palm of the hand) was noted in the right base. There was bronchovesicular breathing, and fine râles at the end of inspiration. The bloody expectoration continued, and the temperature rose to 100. The impression of a pulmonary infarct was recorded.

On the following day a definite 3-1 partial heart block was recorded on the polygraph. During the stay at the hospital, the pulse varied from 52 to 100. The patient was too sick to be moved to the electrocardiograph room.

About eight days later the patient's condition was much worse. He sat up in a semistuporous condition, breathing rapidly, and groaning with each expiration. The lower jaw was dropped, the lip sagging and the tongue protruding. He complained of pain in his hands, legs and abdomen. The heart sounds were distant and weak. A relative cardiac dulness of 5 by 15 + cm. was mapped out, but the apex beat was palpable 10 cm. in the fourth space. The impression of pericardial effusion was recorded.

The urine became alkaline to methyl red, and showed a trace of albumin, with a few pus cells and red blood corpuscles, and a specific gravity around 1.020. The leukocyte count was 10,200, with 75 per cent. polymorphonuclear leukocytes, 4 per cent. large lymphocytes, 18 per cent. small lymphocytes, 1 per cent. eosinophils and 2 per cent. transitionals. The red cell count was 3,600,000. The blood Wassermann reaction was strongly positive. Stereoscopic roentgenograms of the chest revealed the cardiac shadow grossly enlarged in the transverse diameter. The aortic shadow showed a slight widening.

Relation of dissecting aneurysm to aortic valve.

Treatment.—This consisted in rest, sedatives, alkalis, carminatives, cathartics and stimulants when needed. Periods of marked dyspnea were often quickly relieved, following the administration of 8 c.c. of peppermint water, with belching of gas. After fourteen days in the hospital, the patient became weaker and more dyspneic, with continued abdominal pain, and finally died.

Diagnosis.—A clinical diagnosis of aortic insufficiency, relative mitral insufficiency, heart block (cause not known), pericardial effusion, pulmonary infarct, and chronic passive congestion of all viscera with general anasarca, from cardiac decompensation and syphilis, was made.

Necropsy.—This disclosed pericardial effusion, pulmonary infarction, thickened pleura, chronic splenitis, acute cystitis, chronic passive congestion of all viscera, syphilitic aortic endocarditis, cardiac hypertrophy and dilatation with myocardial degeneration, syphilitic mural endocarditis, syphilitic mesaortitis and a dissecting aneurysm in the interventricular septum of the heart.

In Dr. Robert Kehoe's necropsy report on the heart, he notes that "the heart is extremely large, about 20 cm. in the transverse diameter. The musculature is pale and quite flabby. On opening the heart, the tricuspid orifice is dilated so as to admit four fingers. The musculature is slightly thickened. The medial leaflet is dilated and adherent to the interventricular septum, over an opaque area of mural endocardium. The pulmonary valves present no abnormalities. The mitral leaflets are slightly thickened, but not retracted. The aortic valves are markedly thickened and contracted. The median leaflet having a large perforation at its base, the the endocardium beneath being dissected loose, so as to form a cavity within the interventricular septum, just opposite the point of attachment of the median tricuspid leaflet. (The aneurysmal cavity was roughly oval, measuring about 4.5 by 6 cm.). Over this entire area of the septum, over the leaflets of the aortic valves, and extending up into the aorta, there are numerous pearly white plaques, with a great thickening of the endocardium and the intima of the aorta, with much wrinkling. The condition extends into the aorta well below the diaphragm. At one point in the aorta there is a very small dilatation, about the size of a split pea. The mitral valve admits three fingers. The musculature of the left ventricle is of about normal thickness, even though the ventricle is dilated almost to twice the normal size."

COMMENT

In the illustration, the relation of the dissecting aneurysm (cut open) to the aortic valve can be seen. The sac is lined by well developed fibrous tissue, having an appearance similar to that of the endocardium, showing the process to be of some duration. Although the patient complained of dyspnea, the acute attack, which may have corresponded to the development of the aneurysm, was about nine months previous to his death.

The case is interesting since there seems to be a definite anatomic lesion—the aneurysm in the interventricular wall related to the heart block observed clinically. The dilatation and decompensation ordinarily would have been treated clinically by means of one of the digitalis preparations, but in the absence of a definite history it was considered inadvisable to use them in the presence of a pulse of from 40 to 60 per minute.

On admission, the possibility of a digitalis heart block was considered, but this did not seem probable after a week or more in which it was known that the patient did not receive the drug.

SUMMARY

In a case of dissecting aneurysm in the interventricular septum of the heart, and associated with heart block, the diagnosis was clouded during life by an associated aortic and mitral insufficiency and a pericardial effusion. The process was continuous with and related to a syphilitic endocarditis and aortitis. The possible duration of the aneurysm was about nine months. The symptoms present were not abnormal for the other lesions found at necropsy.

MALIGNANT ADENOPATHY OF BONES OF FOOT, PROBABLY OF THYROID GLAND ORIGIN

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History.—A woman, aged 40, complained of throbbing pain in the leg and great toe when extended. She felt "run down," without apparent cause. She was born and had always lived

Fig. 1.—Appearance of leg and foot with muscles dissected away, showing tumor growths in fibula and fifth metatarsal bone.

in the United States, and came from Irish parentage. She had lived in the country or a village during her whole life. The environment and food appeared to have nothing to do with the development of the disease reported here. Chronic constipation had been noticeable, but caused no more than ordinary discomfort. The common contagious and infectious diseases noted were measles at 4 or 5, parotitis at 9 or 10, and pertussis at 4 or 5 and again at 39, when there was an accompanying attack of diphtheria. She had one child at 35, and had had no miscarriages. Menstruation began at 12; the periods were sometimes irregular and occurred at two weeks intervals. Slight dysmenorrhea had always been present.

In the fall of 1911 she had the thyroid gland removed, and was told that the gland contained a tumor. Her health was good until May, 1916, when she had lumbago and had a very tired feeling. Shoes worn at about this time were too small, and the toe was pinched. Later the toe became inflamed and then "broke down," but finally formed granulation tissue and healed. In September, 1916, throbbing, dull pains were noticed in the toes of one foot, and a roentgenogram at that time disclosed a distinct loss of bone substance of the toes, four of which were removed at two operations.

For a brief interval there were no new developments; but after about a year and a half a swelling was noted on the dorsum of the foot and on the right ankle. The tumor mass was soft and painless to palpation and also to the needle. The roentgen ray disclosed a definite loss of bone substance of the fibula and the fifth metatarsal bone, with little or no involvement of the joints. Microscopic examination of the blood revealed a slight secondary anemia; the blood culture was negative; the Wassermann test of the blood was negative, and the blood urea, creatinin, uric acid and blood sugar were all normal. The urinary analysis was normal and tests for Bence-Jones bodies in the urine were negative.

Roentgenograms of all the other bones of the body were negative, and this finding was supported by the negative physical examination. The systolic blood pressure was 116. Temperature, pulse and respirations were normal. Because of the continued dull pain in the leg and great toe, after seeing several men, her physician referred her to Dr. Howard Prince of Rochester, N. Y., who made a clinical diagnosis of a bone tumor of probable thyroid origin. The great toe was amputated for pathologic diagnosis, and sections showed a malignant and rapidly growing adenoma. Consultation with Dr. F. B. Mallory of Harvard Medical School confirmed the diagnosis; in view of the history the opinion was that the origin was probably from the thyroid gland. Histologically it is impossible to say positively that such is the case.

Following the histologic studies, the leg of the patient was amputated by Dr. Prince at a point several inches above the tumor masses shown in the roentgenograms in the hope that the neoplasm might be primary at this site rather than metastatic from the thyroid gland tumor that was reported to have been removed some seven years previously. At the time of operation the patient reported that she felt a tingling sensation in the toes of the other foot similar to that felt in the early development of the neoplasm in the toes affected. This was probably unimportant, for the patient reported to Dr. Prince at the end of one year, and no new developments had taken place and she was apparently in good condition.

Description of Tumor.—The tumor masses appear to have developed in the shaft of the bone in the cancellous tissue or bone marrow, and to have grown by peripheral development up to a diameter twice that of the bone itself. There was a slow erosion and absorption of bone substance, and the tumor mass was encased in a firm fibrous tissue covering. The fibula was involved at a point midway between the head and the external malleolus and a portion of the shaft normally covered by skin and subcutaneous tissues. The bones of the foot involved included the cuboid, the fifth metatarsal bone and all the phalanges of the foot affected.

The tumor mass was soft, glandular and cream pink, and was encased with a firm fibrous tissue covering. The blood supply was of small blood vessel and capillary types.

The microscopic sections show in parts typical adenomatous arrangement of a cuboidal epithelium containing reticular chromatic nuclei. In most parts of the section the tissue is divided into a general reticular or fenestrated arrangement

Fig. 2.—Malignant adenoma, × 140.

by single rows of fibrous connective tissue cells with overlapping ends, and within the spaces so formed are found masses of epithelial cells undergoing rapid proliferation. Numerous karyokinetic figures in the spirem and diaster stages were found. In none of the sections has it been possible to find colloid deposits, and it is impossible to state that the neoplasm is derived by metastasis from the tumor of the thyroid reported to have been found in 1911.

Gland structures of similar reticular arrangement are commonly found in cases of exophthalmic goiter, in which the outlines of the follicles are present and the cells form massed layers which fill the spaces.

A review of the literature shows that similar bone tumors of thyroid gland origin have been noted from time to time; but none have been so fortunately located as to do a minimum amount of damage to the health of the patient, as is found in this case.

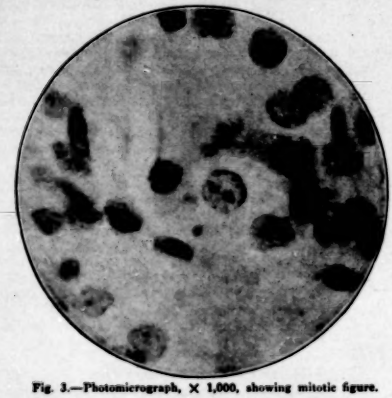

Fig. 3.—Photomicrograph, × 1,000, showing mitotic figure.

Semon,[1] in 1892, reported an extension of thyroid growth to the trachea. Willett,[2] in 1891, reported a case at the St. Bartholomew Hospital in which the tumor of true thyroid structure had lodged in the bodies of the fourth and fifth cervical vertebrae and laid in and partly replaced the bone substance. Martin-Durr,[3] in 1894, reported a neoplasm showing metastases in the pleura and humeri which fractured spontaneously. Mignon and Bellot,[4] in 1910, reported an interesting case of a metastatic thyroid tumor 4 by 5 cm. that lodged in the dorsolumbar vertebral column. The neoplasm was red, and the structure was glandular, friable and showed extensions into the muscles. Sections contained typical thyroid gland colloid, and the histologic examinations showed the tumor to be of a low grade, indolent character.[5]

1. Semon: A Case of Malignant Disease of the Thyroid Gland with Most Unusual Course, Med. Chir. Tr. London, **75**: 375-390, 1892-1893.
2. Willett, E.: Case of Malignant Disease of Thyroid Gland Involving Oesophagus and Cervical Vertebrae with a Deposit of Thyroid Tissue in the Bone, Tr. Path. Soc. London **42**: 144, 1891-1892.
3. Martin-Durr: Epithélioma du corps thyroide; metastase dans les plèvres et dans les deux humérus qui sont fracturés spontanément, Bull. Soc. anat. de Paris, **69**: 240-243, 1894.
4. Mignon and Bellot: Metastase d'un cancer latent de la glande thyroide dans le segment dorso-lumbaire de la colonne vertebrale, Presse méd. **18**: 809, 1910.
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RECONSTRUCTION OF HARD PALATE WITH CARTILAGE TRANSPLANT

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It is perhaps to the late Dr. Morestin of Paris, more than to any other surgeon, that we owe the popularization of the use of cartilage transplantation for the repair of defects of the hard parts, particularly about the head and face.

When repair of a defect is undertaken for none but cosmetic reasons, if the defect involves even in only slight degree the skeletal structures, it is my opinion that any process for the repair of the defect which does not comprise measures for the repair of the underlying skeletal defect is a faulty process and is not likely to be followed by the best results.

In the repair of cleft palate—that most common of congenital defects—repair of the bony part of the palate is hardly ever considered. This is as it should be, for its consideration is hardly ever necessary. The reason is that repair of the bony defect does take place (in most of the cases) even though the surgeon when operating makes no attempt to close the opening with bone. However, as said above, in all of those repaired, more or less new bone forms from the mucoperiosteal flaps, and in those repaired very early in infancy it is the rule for complete bony restoration to occur.

Certain wounds of the head or face have resulted in the total loss of the upper jaws. These patients have up to the present been obliged to depend on the ingenuity of our dental colleagues for some form of mechanical contrivance to replace the lost maxillae. And although these devices are very skilfully designed and

Fig. 1.—Width of opening as compared with widths of palate processes.

cleverly made, they yet leave much to be desired, and it seems to me that the method of cartilage transplantation here described could in many of those cases be utilized to great advantage.

Defects in the lower jaw were repaired with cartilage by Morestin, and he considered the results excellent. Defects in the upper jaw he repaired with

cartilage or bone, but he was not enthusiastic for either cartilage or bone transplantation in any case in which the wound had entrance to the oral cavity.[1]

The method here described and illustrated in the accompanying case report may be used to transplant cartilage from a distance into the mouth without the usual danger of losing the graft should suppuration supervene, or wherever it is necessary to repair hard and soft parts together.

Fig. 2.—The skin and platysma was dissected up leaving it attached at both ends. Its edges were then sewed together and the defect in the neck was closed. At the lower end of the pedicle the outline of the cartilage under the skin can be seen.

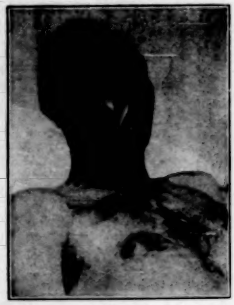

Fig. 3.—The flap has been freed from its attachment below and is now fastened to the defect in the palate. The jaws were blocked open and the patient bore the inconvenience of this for a little more than two weeks, at the end of which time the pedicle was gradually cut through.

REPORT OF CASE

First Operation.—Private B., aged 23, brought to me by my dental colleagues at A. R. C. M. H. No. 1, in 1918, had the widest congenital cleft palate that I have ever seen. My colleagues wanted to know whether I would attempt the closure of the soft palate, for if I would they would make him an obturator for the opening in the hard palate. I had not much heart for the operation, but since the patient knew it was likely to fail and yet was anxious to have it done I undertook it and under local anesthesia closed it in the usual way, but broke the hamular process on each side in order to relieve the pull of the palatal tensor muscles. The patient was very anxious for success, and for two weeks he introduced his food and drink through a tube well down to the bottom of his pharynx, kept his breath sweet by frequent mouth washing, and did not even whisper. The result was entire success.

The patient now became anxious that I should make some attempt to close the defect in the hard palate. The opening was 20 mm. wide in the premolar region, and the distance from the teeth to the edge was 10 mm. on the right side and 12 mm. on the left. The ordinary procedures were thus not to be considered. Of course, one could obtain a flap from the cheek, but the patient had perfect teeth and I did not care to sacrifice any of them; therefore, after complete explanation to the patient he decided to have a flap of skin instead and I suggested that we try also to insert cartilage to take the place of the missing bone.

Second Operation.—Under local anesthesia, the sixth cartilage on the right side was exposed and a portion about 40 mm. long was removed from its anterior surface. The piece removed was about 6 mm. thick. The perichondrium was not removed from it and the piece was then trimmed to correspond roughly to the shape and size of the cleft, but a little larger, and through a small incision implanted under the skin (and very close to it) about an inch to the right of the sternum in the region of the second interspace. The periosteal surface was placed next to the skin. All wounds closed. Healing occurred by first intention and the next step was taken.

Third Operation.—For the purpose of making a tubed pedicle for a flap, a flap, base upward, was outlined over the buried cartilage, care being taken that the line for incision should lie at least 18 mm. away from the cartilage and should pass through the scar of the incision through which the cartilage was inserted. The outlining of this flap was done in pencil in order that we might properly place the pedicle. Under local anesthesia, two incisions were now made parallel to and from 40 to 45 mm. from each other, beginning in the right submaxillary region and ending at the base of the flap outlined in pencil. The intervening strip of skin *and platysma* was dissected up but left attached to each end. Its edges were sewed together with interrupted silkworm-gut sutures. The skin of the neck and chest was now undermined and the defect closed with silkworm-gut sutures. Healing occurred by first intention.

Fourth Operation.—Under local anesthesia, again a flap was outlined over the cartilage as in the third operation, but this time it was turned up toward the tubed pedicle but was not entirely lifted up as I was not yet sure that blood enough would come so far—6 inches—through the tubed pedicle. This flap consisted of skin and from 8 to 1 mm. of fat, and contained the implanted cartilage. Another flap just as large as this with its base toward the right side of this and 1 inch away from it was dissected up and turned over backward, and passed under the first one, their raw surfaces in apposition. Their edges were sewed together and both defects closed.

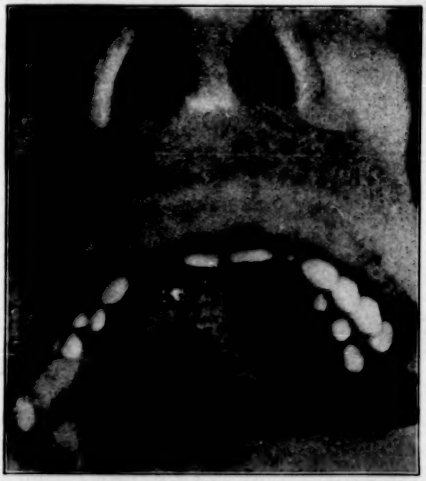

Fig. 4.—Present appearance. Result perfect. Some short hairs are seen growing from the new palate.

Healing occurred as before, and after ten days I began to cut the pedicle of the last flap, cutting a little each day until in about ten days it was quite free.

The patient was then evacuated and I did not see him again until May, 1919. He had in the meantime passed through many hospitals, and, thanks to my colleagues Drs. Dorrance of Philadelphia, Schaefer of Columbus and Potts of Chicago,

1. Personal communication to the author.

he had been sent to me. However, when he reached me I was about to be discharged; and as permission to finish the case was not granted me, the patient secured his discharge and the case was completed at St. John's Hospital here.

Fifth Operation.—Under local anesthesia, the edges of the palatal defect were pared and the mucoperiosteum separated from the bone back 5 mm. from the edge on both sides. The edges of the flap were now pared until the flap would just fit in the opening. The edge was split a little so that the skin could be everted into the nose and mouth, respectively. The flap was then sutured into the defect and the mouth blocked open.

Again the patient cooperated. The mouth was kept clean, and in two weeks union was firm. The pedicle was then cut through a little every day till finally it was cut off. A small fistula persisted in front, but after one cauterization it closed. The rhinologist, Dr. Pfingsten, reported the condition perfect in the nasal floor some time in the fourth week.

Result.—At present the condition is perfect, and the bit of cartilage is firm in position and seems to be just as large as it was when I implanted it in 1918.

This is reported, not as an example of "trick surgery," but to illustrate the fact that cartilage may by this method be transplanted into the mouth and thus a foundation for a prosthesis be established in cases of loss of the upper jaw. And it was such cases I had in mind when I undertook this work.

405 University Club Building.

Clinical Notes, Suggestions, and New Instruments

A CASE OF METHYL SALICYLATE POISONING

HAROLD B. MYERS, M.D., PORTLAND, ORE.
Professor of Pharmacology, University of Oregon Medical School

J. W., aged 2, obtained a bottle containing 1 ounce of methyl salicylate and drank the contents. A druggist advised giving olive oil as an antidote, assuring the mother that the dose was not dangerous. Services of a physician were therefore not requested as soon as they would have been if the danger had been appreciated at the start.

Gastric discomfort soon manifested itself, followed by nausea and vomiting about one hour after the salicylate had been taken. The vomitus contained some cereal eaten about two hours previously, with considerable mucus having a strong odor of wintergreen. Nausea continued for several hours, with occasional vomiting of tenacious mucus. No blood was observed at any time in the vomitus. Diarrhea did not occur, but there was frequent and copious urination. The odor of the urine was not noticed during the first twenty-four hours. The odor of methyl salicylate was present in the urine voided during the second day of the poisoning. This urine was of amber color and without a trace of albumin.

The child was restless during the first night and complained of hearing noises. A specialist in children's diseases was called twenty-four hours after the salicylate was swallowed. He found the child drowsy, though rational when pressed with questions. The eyes were rotated upward when the patient was allowed to lie undisturbed. There was no evidence of visual impairment. The temperature was normal. Physical examination revealed nothing abnormal except a slight acceleration in the rate of respiration and of cardiac pulsation.

Between the twenty-fourth and twenty-seventh hours after the salicylate was taken, the rate and amplitude of respirations increased until the picture of air hunger was present. The ventral wall from clavicle to pubis rose and fell from forty-eight to fifty-four times a minute. The expired air had a distinct odor of acetone. Analysis of the urine revealed an amount of acetone similar to that found in diabetic coma.

Sodium bicarbonate was given by mouth and by rectum. The respiratory distress decreased, though no apparent decrease was noticed in the acetonuria. The respiratory rate and excursion were normal forty hours after taking the salicylate. A few hours later, sudden symptoms of dyspnea occurred, followed by cessation of voluntary respirations. Artificial respiration was performed for several minutes, following which voluntary respiratory movements returned. Respiratory distress soon disappeared, and the patient's recovery thereafter was uneventful.

COMMENT

The outstanding feature of this case of methyl salicylate poisoning is the symptomatic evidence of a marked stimulation followed by a pronounced depression of the respiratory center, accompanied by acetonuria.

Clinical reports of salicylate poisoning, and experimental results on animals, indicate that the poisoning is essentially similar, irrespective of the form in which the salicylate is taken.

New and Nonofficial Remedies

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION. W. A. PUCKNER, SECRETARY.

TYPHOID VACCINE (See New and Nonofficial Remedies, 1920, p. 291). Lederle Antitoxin Laboratories, New York.

Typphoid Glycerol-Vaccine (Prophylactic)-Lederle. — A suspension of killed typhoid bacteria (Rawling's strain) in a vehicle composed of glycerol 66 per cent., physiologic solution of sodium chloride 33 per cent. and cresol 1 per cent. The product is supplied in packages of 3 vials containing the glycerol-vaccine and of 3 vials of sterile diluent with which to make the proper dilution of the vaccine at the time of injection. Each dose consists of 0.1 Cc. of typhoid glycerol-vaccine (the concentration of the killed bacteria for the first dose is one-half as great as for the second or third dose) and 0.9 Cc. of sterile physiologic solution of sodium chloride. After dilution, the first dose contains 500 million killed bacteria; the second and third doses contain 1,000 million killed bacteria each.

Typhoid Combined Glycerol-Vaccine (Prophylactic)-Lederle. —A suspension of killed typhoid bacteria (Rawling's strain), paratyphoid A and paratyphoid B (one-half portion typhoid bacteria, one-fourth portion paratyphoid A and one-fourth portion paratyphoid B) in a vehicle composed of glycerol 66 per cent., physiologic solution of sodium chloride 33 per cent. and cresol 1 per cent. The product is supplied in packages of 3 vials containing the glycerol-vaccine and 3 vials of sterile diluent with which to make the proper dilution of the vaccine at the time of injection. Each dose consists of 0.1 Cc. of Combined Typhoid Glycerol-Vaccine (the concentration of the killed bacteria for the first dose is one-half as great as for the second or third dose) and 0.9 Cc. of sterile physiologic solution of sodium chloride. After dilution, the first dose contains 500 million killed typhoid bacteria, 250 million of killed paratyphoid A and 250 million killed paratyphoid B bacteria; the second dose and third dose each contain 1,000 million killed typhoid bacteria 500 million killed paratyphoid A and 500 million paratyphoid B bacteria.

The Antiquackery Monthly.—A small monthly is published at Amsterdam, now in its fortieth year, which is devoted to the exposure of quackery of all kinds. The subscription price is 1.25 florins per year, and the address of the secretary is Dr. W. Binnendijk, Marnixstraat 182, Amsterdam. The latest issue reports the annual meeting of the Antiquackery Society, and the recent sentencing to two months' imprisonment of the quack Eilers. Members of the society send in queries and information about quacks, the correspondence department filling considerable space. Any one making a contribution of 3 florins to the work is entitled to membership.

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SATURDAY, DECEMBER 25, 1920

FUNCTIONAL ACTIVITY OF THE CAPILLARIES AND VENULES

The distribution of blood throughout the body is dependent not only on the pumping mechanism of the heart but also on peripheral factors that are centered in the blood vessels themselves. The latter are subjected to influences, designated as vasomotor in character, which alter the peripheral resistance and correspondingly the blood supply to the tissues concerned, by variations in the caliber of blood vessels. In the early development of the knowledge of this chapter of physiology, these vasomotor functions were conceived to be controlled essentially by nervous influences. The nervous control of the peripheral resistance was alleged to take place through the action of vasoconstrictor and vasodilator nerve fibers on the musculature of the arteriole walls.

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And a Happy and Prosperous New Year

Subsequently, the possibility of a chemical regulation of the blood vessels began to be brought into the domain of consideration in explaining the blood flow through various organs. It was recognized that their vessels exhibit a sensibility to products of cellular activity. Local vascular dilatation in particular was often explained in this way, without any clear-cut conclusions as to the precise location of such change. The implication continued, however, that metabolites or drugs which produced a vasomotor action not clearly attributable to an effect on well known vasomotor nerve factors might act on a local nervous mechanism in the arterioles, or perhaps even directly on the musculature of the latter.

More recently, however, as has been pointed out before in THE JOURNAL,[1] the ability of the capillaries themselves to undergo changes in caliber actively rather than merely passively has attracted attention. The evidence is accumulating to show that they can dilate or contract individually and independently of the larger blood vessels with which they are in uninterrupted connection. Hooker[2] of the laboratory of physiology at Johns Hopkins University has lately contributed further evidence that the functional peripheral resistance is not limited to the arterioles, but includes the capillaries and venules as well. It is inferred that this resistance is subject to chemical as well as nervous control. He has described an ingenious method whereby the capillary circulation may be observed and even photographed in the living mammal. Hooker's findings, which are quite in harmony with many conspicuous facts of the physiology of the circulation, and likewise with Krogh's recent publications on the "capillariomotor" mechanism of the body,[1] are contrary to the present widespread belief that the active functional peripheral resistance is to be found wholly in the smaller arterioles with smooth muscle in their coats. The evidence given indicates that nerve impulses along vasomotor fibers may play upon the caliber not only of the arterioles but also of the capillaries and venules. In accord with these views we must therefore modify our conception of the peripheral resistance in the matter of functional activity to cover the whole peripheral vascular bed, including the arterioles, capillaries and venules.

The conception that all parts of the vascular apparatus, including the arterioles, capillaries and venules, can be affected by both nervous and chemical factors greatly complicates the conception of the regulation of the circulation in definite organs and tissue areas. It suggests the possibility of specific control for what were before supposed to be merely passive parts of the circulation. In the light of the newer knowledge, Hooker[2] writes, we may conceive of a highly organized nervous mechanism adapted to quick and efficient response superimposed upon the primitive chemical methods available to the organism. There is doubtless a happy coaptation between these two major processes of control; but on the body surface, exposed to noxious environmental factors, and in the voluntary muscles where quick adjustments of blood supply are constantly demanded, we might expect the nervous regulation to play a significant teleologic rôle. In the glands and deeper body tissues generally, on the other hand, where reaction time is of less significance, responses may largely depend on chemical factors for their instigation.

1. Vasomotor Changes and the Capillary Mechanism, Current Comment, J. A. M. A. 75:1209 (Oct. 30) 1920.

2. Hooker, D. R.: The Functional Activity of the Capillaries and Venules, Am. J. Physiol. 54:30 (Nov. 1) 1920.

The reorganization of our current beliefs and the conferring of new physiologic powers on the capillaries and venules suggest new consideration of clinical phenomena admittedly of a capillary nature. What is the bearing of alterations in "capillary tone" on those instances of vasomotor instability that have been described as vasomotor or capillary ataxia? Will the newer information furnish an explanation of Marey's tache, the peculiar appearance of the skin which follows the application of a blunt instrument across its surface in certain cases, notably those of so-called irritable heart?[3] Perhaps, as Hooker points out, in a highly organized device for the disposition and partition of the blood by which extensive capillary beds may be largely emptied of or packed with corpuscular elements or plasma, an explanation is readily found for the uncertainties of blood cell counts and blood volume determinations. At any rate, hereafter attention must be focused on more localities in the vascular bed than those which were thought of foremost if not sole significance only a few years ago.

SURVEY OF EXECUTIVE GOVERNMENT WITH VIEW TO REORGANIZATION

The House of Representatives, December 14, passed by a unanimous vote Senate Joint Resolution 191, which passed the Senate, May 10. This resolution creates a Joint Committee on Reorganization, to consist of three senators and three members of the House, which is to make a survey of the administrative services of the federal government; to secure pertinent facts regarding their powers, duties and distribution, with any overlapping or duplication which may exist, and to recommend what redistribution of activities should be made so that the largest amount of efficiency and economy may be secured. The passage of the resolution is the first step in the reorganization of the executive government. It has long been recognized that there exists a large amount of overlapping and duplication of function, as well as a lack of orderly and systematic grouping, in the various bureaus and divisions making up the ten departments.

In no instance is this more striking than in public health matters. An unofficial survey, recently made, showed that there were thirty-four independent government organizations carrying on some kind of work directly relating to public health. These organizations, instead of being closely correlated, are scattered throughout the different departments. In the Treasury Department are the U. S. Public Health Service and the War Risk Insurance Bureau. The Children's Bureau is in the Department of Labor. The Division of School Hygiene and Physical Education of the Bureau of Education, the Indian Medical Service and the Government Hospital for the Insane are under the Department of the Interior. The Department of Agriculture has Bureaus of Chemistry, Animal Industry, Entomology and Biology, all of which are performing some health functions. In the Department of Commerce, the Bureau of the Census conducts the Division of Vital Statistics, the human bookkeeping system of the federal government. The War Department and the Navy Department has each its own medical service. Independent commissions and boards, such as the Interdepartmental Hygiene Board, the Federal Board for Vocational Training, the Bureau of Safety of the Interstate Commerce Commission, and the medical service of the government printing office, are unrelated to any of the other health agencies of the government. An enumeration of the work of these thirty-four separate organizations, even in general terms, would require pages of space. Regardless of the possibility or desirability of any increase or extension of federal public health work, the need of organizing and correlating these numerous agencies is too evident to require discussion. Entirely aside from its public health aspect, readjustment of the federal machinery is necessary purely for administrative reasons.

It has been evident for some time that a general rearrangement of the entire executive government is inevitable. The unanimous adoption of this resolution by both houses of Congress shows that this need is recognized by both parties, and that the coming change of administration is regarded as the best time for such reorganization. In the program of this committee, public health should be one of the first and most important subjects considered. The hearings before this committee will afford an opportunity for every one interested in the development and expansion of federal public health work to present his views for consideration. Out of the discussion and investigation that will result should come a well planned and coordinated federal health organization.

HELMINTHIASIS AND ANEMIA

The nature of the harm that is attributable to intestinal helminthiasis, the result of infestation with parasitic worms, has by no means been definitely determined for the various types of invading organisms. Indeed, there is at present no guarantee that the damage which they cause is of the same character in each case. Explanations have included the possibility that mechanical and nervous as well as chemical factors may have some responsibility for the untoward consequences of harboring such worms. In some cases the symptoms of the hosts are similar to those of anaphylactic intoxication, thus suggesting the presence of antigenic substances in the parasites and the occasional liberation of these compounds. Sometimes the suspicion of a more direct intoxication from secreted poisons is aroused in the clinical observer; for it is easy to conceive of the discharge of highly toxic products, resem-

3. Ryan: Am. J. Physiol. 48: 537, 1918. Cotton, T. F.; Slade, J. G., and Lewis, T.: Heart 6: 227, 1917.

bling alkaloids in potency, directly into the bowel in which the parasites are present and may even be disintegrating.

Since the chief pathologic effect of certain parasitic worms seems to be an anemia, the presence in them of hemolysins is at once brought to mind. Such products have, in fact, repeatedly been extracted from certain types of intestinal parasites that produce anemia. Whipple,[1] who has observed a weak hemolysin in the American hookworm, considers it too ineffective to be of practical importance. Recently, Schwartz [2] of the Bureau of Animal Industry has examined a number of common parasites, such as species of *Ascaris*, of *Ancylostoma*, a hookworm belonging to the genus *Bustomum*, species of *Trichuris*, species of two genera of anoplocephaline cestodes, and several other forms. From these, hemolysins, not specific to the blood of the hosts alone, have been obtained in each case. At one time the hemolytic effect of such parasitic worms was ascribed, largely as the result of the studies of Faust [3] and his co-workers, to oleic and perhaps other fatty acids. The new American results seem to show, however, that different agents must be involved.

It is not easy to demonstrate that the hemolysins separated in the laboratory from the parasitic organisms are the determining factors in the actual pathogenesis of helminthiasis. Nevertheless Schwartz believes that the view that parasitic worms secrete toxic substances that are absorbed by the host not only affords a better explanation of the toxic symptoms of helminthiasis than the theory of "reflex action," but also affords an explanation of certain aspects of the pathology of helminthiasis that are inexplicable on the basis of any other view that has thus far been advanced.

STATUS OF THE ABDERHALDEN REACTION

Few novelties in clinical medicine have received more extensive discussion than the so-called Abderhalden reaction, which was first introduced as a method for the diagnosis of pregnancy and was subsequently applied to cancer, degenerative changes in the nervous system, and some other forms of organic disease.[4] The underlying idea is that "the animal body reacts to the presence of foreign proteins by providing specific means of destroying them through proteolysis." Applied in the case of pregnancy, this was interpreted to mean that the chorionic cells of the placenta enter the maternal circulation, whereupon their foreign proteins provoke the formation of the protective enzymes —"Abwehrfermente"—which can in turn be detected by the ability of serum containing them to digest suitably prepared placental protein in vitro.

Obviously, the importance of these claims and discoveries rests above all on the specificity of the reactions. Proteolytic enzymes may occur widespread in the tissues and fluids of the body; but the presence of special types which react with only a single group of protein substrates involves something of biochemical novelty. The reactions are at best not rapid or conspicuous, being in this respect quite unlike what the student of digestive proteolysis might expect. Accordingly, it became necessary for the champions of the new mechanism of immunologic defense to devise a highly refined technic for the detection of the specific serum enzymes.

It would be unprofitable to review here the enormous literature which this subject has produced.[5] Claims of noncorroboration and nonspecificity by experimental critics have usually been countered with the charge that the demonstration demands a special technic and proper chemical manipulation to elucidate the subject. Nevertheless, skilled investigators have failed to secure evidence of specificity, the placenta-digesting reaction often being reported to be quite as conspicuous with the serum of males and nonpregnant women as with that of pregnant persons. Papers that were published in Europe during the war now bring the news that experimentalists trained in Abderhalden's own laboratory can no longer endorse his views. Thus, Oppler [6] has subjected the underlying hypotheses as well as the experimental possibilities to an elaborate reinvestigation at the Medical Policlinic in Munich. His results and deductions alike are adverse to any further support of the widely heralded and intensely debated Abderhalden reaction. Wells,[7] who also has had large experience in the study of this alleged immunity reaction, has pointed to the "absolutely nonspecific and hopelessly paradoxical results" now so frequently recorded. He, too, insists that the diagnostic value of the Abderhalden reaction for either clinical or scientific purposes must be considered at present unproved, whatever the final decision as to its standing as a specific reaction may be. The unwarranted enthusiasm which it once aroused should serve as a lesson and warning against the too ready acceptance of novelties in any domain of science.

1. Whipple, G. H.: J. Exper. Med. **11**:331, 1909.

2. Schwartz, B.: A Blood Destroying Substance in Ascaris Lumbricoides, J. Agric. Res. **10**:253 (March 3) 1919; Hemolysins from Parasitic Worms, Arch. Int. Med. **26**:431 (Oct.) 1920.

3. Faust, E. S., and Tallqvist, T. W.: Ueber die Ursachen der Bothriocephalusanämie, Ein Beitrag zur Pathogenese der perniziösen Anämie auf physiologischchemischer Grundlage, Arch. f. exper. Path. u. Pharmakol. **57**:367 (Nov. 21) 1907. Faust, E. S.: Ueber experimentelle Anämien, Berl. klin. Wchnschr. **45**:2121 (Nov. 23) 1908. Flury, F., and Schmincke, A.: Ueber das Verhalten der Erythrocyten bei chronischer Oelsäurevergiftung, Arch. f. exper. Path. u. Pharmakol. **64**:126, 1911. Flury, F.: Zur Chemie und Toxikologie der Ascariden, ibid. **67**:275 (March 26) 1912.

4. Abderhalden, E.: Abwehrfermente des tierischen Organismus. Several editions have already appeared.

5. Reviews are given by: Bronfenbrenner, J.: On the Present Status of the Abderhalden Reaction and Theory of the So-Called Abwehrfermente, J. Lab. & Clin. Med. **1**:79, 1915. Wallis, R. L. M.: The Protective Ferments of the Body, Quart. J. Med. **9**:138 (Jan.) 1916. Abderhalden, E.: Fermentforschung **1**:315, 1916. Van Slyke, D. D.: The Present Significance of the Amino-Acids in Physiology and Pathology, Arch. Int. Med. **19**:56 (Jan.) 1917.

6. Oppler, B.: Kritisch-experimentelle Untersuchungen über Abderhaldens "spezifische" Abwehrfermente, Biochem. Ztschr. **78**:211 (July 6) 1916.

7. Wells, H. G.: Chemical Pathology, Ed. 4, Philadelphia, W. B. Saunders Company, 1920, p. 205.

Current Comment

IS OLEIC ACID A CAUSE OF ANEMIA?

As anemias frequently attend infestation with certain intestinal parasites, notably several species of worms, and as hemolytic substances have actually been isolated from the bodies of the parasitic organisms, the characteristic decrease in red corpuscles has naturally been ascribed to the hemolysins thus discovered. It must be admitted, however, that in some instances at least, the anemias thus encountered are directly attributable to hemorrhages from the bowel. This is true after infestations with hookworm. Among the chemical products held responsible for the anemias following parasitic invasion, oleic acid and some of its compounds have been in the forefront of discussion for more than a decade. This is due especially to the studies of the intestinal cestode worm *Bothriocephalus*, from which Faust [1] and his collaborators isolated oleic acid esters which they regarded as the noxious principle. They believe, further, that the ingestion of considerable quantities of oleic acid could give rise to distinct anemia in animals. The hypothesis, with the submitted evidence, was at first widely accepted because of its specific and striking character; but the investigations of Beumer [2] of Duesseldorf have failed to substantiate the harmfulness of oleic acid, particularly as a hemolytic cause of anemia. Animals were fed daily with considerable doses for long periods without permanently untoward effects, which, after all, is what one might expect. The diet of man commonly contains not negligible amounts of fats that yield oleic acid by digestion. It would be surprising to find that a potential menace was thus being included day after day in what is usually regarded as a normal and wholesome diet.

CHLOROFORM AND EPINEPHRIN

It is well known that heavy doses of chloroform may produce a toxic effect on the heart, manifesting itself in weakness and consequent dilatation. The degree of danger, why it arises, and how it may be averted are topics that have been answered in various ways.[3] Nevertheless, it is generally admitted that even with the most careful administration of chloroform, the blood pressure may fall progressively, and the heart tends to suffer weakness in consequence. To counteract this, particularly in emergencies of consequent circulatory failure, the intravenous injection of epinephrin has been proposed with the object of restoring the arterial pressure in the now well-known manner characteristic for this potent drug. Heinekamp [4] of the University of Illinois College of Medicine has now joined others in warning against the simultaneous use of chloroform and epinephrin. The latter, by increasing the peripheral pressure, causes a high aortic pressure against which a weakened and frequently dilated heart damaged by chloroform cannot empty itself. The added load thrown upon a weakened organ may induce further dilatation and even fibrillation. The two drugs, chloroform and epinephrin, should accordingly not be administered at the same time. Each is contraindicated when the other has been used.

1. Faust and Tallqvist: Arch. f. exper. Path. u. Pharmakol. **87**: 367, 1907.
2. Beumer, H.: Zur pathogenetischen Bedeutung der Oelsäure bei Anämien, Biochem. Ztschr. **98**: 239 (July) 1919.
3. Hatcher, R. A., and Wilbert, M. I.: Pharmacology of Useful Drugs, Chicago, American Medical Association, 1915, p. 108.
4. Heinekamp, W. J. R.: The Action of Adrenalin on the Heart, III, The Modification of the Action of Adrenalin by Chloroform, J. Pharmacol. & Exper. Therap. **16**: 247 (Nov.) 1920.

MEDICAL LITERATURE

In the realm of medicine, what to read and what not to read is a serious problem that confronts every physician. Too often he reads without thoughtful discrimination. He gives more thought to the quality of the food he eats than to the character of the medical literature he consumes. Cheap postal service, cheap printing and the greed of commercialism have united to corrupt and deceive the unwary physician. Quick to resent the brazen quackery flouted from the pages of the lay press, he is slow to recognize the same commercial wolf in sheep's clothing, disguised in a medical journal. Brochures from pharmaceutic houses are so skilfully cloaked in the guise of science that the commercial animus back of it all is unobserved. Some of the literature emanating from such sources is highly scientific and trustworthy. Taken all in all, however, the conclusions drawn are usually insufficiently supported by data worthy of credence. Let the physician always suspect the commercial motive of the appeal. He should scan hastily and with a critical eye, reserving time for medical literature that emanates from entirely trustworthy sources.

THE LIFE PROTECTION ASSOCIATION OF CANADA

Commercializing medical practice seems to be in the air and spreading—even into Canada. As evidence we cite the prospectus—just received—announcing the incorporation of "The Life Protection Association of Canada." The "diagnostic board" of this association, we are told, is composed of "outstanding members of the medical profession." It is claimed to be patterned after a similar organization in this country—presumably referring to the Life Extension Institute. "The main object of the Association," so reads the prospectus mentioned, "is by means of a national, continuous advertising campaign to bring home to the public mind the fact that the human machine needs periodical examination as much as an automobile or a piano." However, the real attraction of the circular is financial. On the basis of a stock issue of $300,000, one half common and one half 8 per cent. cumulative preferred, we have the following estimate of earnings: "gross income first year of operating, 20,000 members at $15 each, $300,000"; various expenses, amounting to $227,000, leaving "net earnings, $73,000; dividend preferred stock, $12,000; net to common, or at the rate of over 40 per cent., $61,000." All in the first year! What an attractive investment! It reminds one of the renowned Colonel Sellers and his eye salve!

Medical News

(Physicians will confer a favor by sending for this department items of news of more or less general interest: such as relate to society activities, new hospitals, education, public health, etc.)

ALABAMA

New Officers of Society.—At the annual session of the Mobile Medical Society, December 4, the following officers were elected: president, Dr. William H. Oates; vice president, Dr. Edward S. Sledge; secretary, Dr. Willis W. Scales (reelected), and treasurer, Dr. Edly W. Cawthon (reelected).

Medical Inspector of Prisons Resigns.—Dr. Mack C. Hawkins, Greenville, has resigned his position as medical inspector of the state prisons and convict camps. The work has been placed under supervision of Dr. Glenn Andrews, Montgomery, state prison inspector, who will have full charge of all prisons and prison camps. He will be assisted by Dr. Charles H. Smith, physician at Flat Top prison camp.

CALIFORNIA

Physicians' Annual Tax.—In California there is an annual tax on physicians which is payable January 1 of each year. The penalty for nonpayment after sixty days is automatic revocation of the certificate which requires a $10 fee for reinstatement. On the basis of this annual registration the licensing board prepares a directory of all who are practicing the healing art in the state.

Malpractice of Chiropractors.—Two definite instances showing the menace from chiropractors due to their inferior training have been reported from California. In one instance a chiropractor was treating a child for "a sprain of the arm" which a roentgenogram showed to be a fracture of both bones of the forearm. In the second instance, a tuberculous patient under treatment by a chiropractor grew progressively worse and a roentgenogram showed a right-sided pleural effusion.

FLORIDA

Tuberculosis Society Elects.—The Escambia County Anti-Tuberculosis Association has elected Dr. Fritz A. Brink, Pensacola, president, and Dr. John Turbeville, Century, vice president.

Meeting of County Society.—At the annual meeting of the Hillsborough County Medical Society, held December 7, the following officers were elected: president, Dr. John C. Vinson, Tampa; vice president, Dr. Leland Francis Carlton, Tampa, and secretary, Dr. Charles R. Marney, Tampa.

GEORGIA

Addition to Sanatorium. — The Piedmont Sanitarium, Atlanta, is building an addition of sixty-five rooms to meet increased demands on the institution.

Battey Memorial Committee.—The Seventh District Medical Society, at a meeting held December 1, appointed a committee to secure funds for a memorial to Dr. Robert Battey. The committee is composed of Drs. J. C. Watts and William J. Shaw, Rome, and Dr. Howard Felton, Carterville.

ILLINOIS

Chicago

Personal.—Dr. Ethan A. Gray, superintendent of the Chicago Fresh Air Hospital, has been engaged by the LaSalle County Tuberculosis Sanitarium Board to conduct the monthly clinic, to investigate the work of the sanitarium, and to make recommendations for improving the care of the patients.

Community Trust to Make Survey.—The Chicago Community Trust announces the appointment of a medical plan commission under whose auspices there will be undertaken at once a study of the local institutional facilities devoted to the treatment of the sick and disabled. The commission is headed by Dr. James B. Herrick, and includes a number of representative physicians and institutional and social workers. The sum of $15,000 has been set aside for this purpose.

INDIANA

Personal.—Dr. Merrill Steele has been appointed superintendent of the Methodist Hospital at Fort Wayne.

Leper Under State Care.—The state board of health has assumed responsibility for the care of Robert Burdine, a leper recently discovered in Indianapolis. The Indianapolis City Board of Health will cooperate in maintaining quarantine of the leper and his family.

County Offered Sanatorium Site.—The Smith farm, near Richmond, has been given to Wayne County by Mr. and Mrs. David Esteb, and $50,000 has been promised if the county in turn will appropriate $50,000 in cash for the establishment of a sanatorium as a memorial to the parents of Mrs. Esteb, Mr. and Mrs. George Smith.

County Society Holds Meeting.—A farewell reception was given to Dr. George W. Willeford, dean of the Washington physicians, who is retiring after fifty-two years of practice, at the annual meeting of the Daviess County Medical Society, held at Washington, December 2. The following officers were elected for the new year: president, Dr. William O. McKittrick, Plainville; vice president, Dr. Charles P. Scudder, Washington, and secretary-treasurer, Dr. Austin I. Donaldson, Washington.

LOUISIANA

Personal.—Dr. Warren P. Morrill, formerly superintendent of the University Hospital, Augusta, Ga., has been appointed superintendent of the Charity Hospital at Shreveport.——Dr. John Callan has been appointed superintendent of the New Orleans City Board of Health.

Officers of Ouachita Society.—At the annual session of the Ouachita Medical Society, held at Monroe, December 8, the officers were elected for the ensuing year as follows: president, Dr. Courtland P. Gray; vice president, Dr. George W. Wright, and secretary-treasurer, Dr. James E. Walsworth, all of Monroe.

MARYLAND

Inspect Johns Hopkins Hospital.—To study methods employed in the clinics of Johns Hopkins Hospital, a group of prominent Bohemian physicians recently spent several days in Baltimore. The physicians were under the guidance of Dr. C. W. Wells, New York, and included Drs. Antonin Kolinsky, B. Vacek, Ivan Halek, Vladimir Basika, Vladimir Petrik.

Personal.—Dr. Hugh Hampton Young, Baltimore, director of the James Buchanan Brady Urological Institute of Johns Hopkins Hospital, is now a patient in the medical department of the hospital, suffering from dilatation of the heart. ——Dr. J. Whitridge Williams, Baltimore, dean of the Johns Hopkins Medical School, has resigned as a member of the Board of Supervisors of City Charities, which has control of Bayview Hospital.

Lecture Courses.—A lecture was delivered at the School of Hygiene and Public Health of Johns Hopkins University, December 13, by Dr. Charles Wardell Stiles, U. S. P. H. S., on "Some Practical Aspects of the Subject of Soil Pollution."——Dr. Edward C. Schneider, professor of biology of Wesleyan University, delivered a lecture, December 20, on the "Influence of High Altitude on Man," at the School of Hygiene and Public Health of Johns Hopkins University.

MINNESOTA

Election of Officers.—At the meeting of the Southern Minnesota Medical Association, held at Mankato, Dr. William J. McCarthy, Madelia, was elected president, and Drs. Edward D. Keys, Winona, and Walter R. Ramsey, St. Paul, vice presidents.

Tuberculosis Fellowships Offered University.—Two fellowships for research in tuberculosis have been offered to the University of Minnesota, according to a recent announcement. Dr. H. Longstreet Taylor, St. Paul, has offered an annual fellowship of $1,000, and the Hennepin County Tuberculosis Association has offered a fellowship of $750.

Medical Officers' Reunion.—At a meeting in St. Paul, December 8, it was decided to call a reunion of all former medical officers resident in the Northwest, during clinic week, to be held in St. Paul, Jan. 10-15, 1921. The committee, consisting of Drs. P. J. Maloney, F. J. Savage, Charles Freeman and Knox Bacon, all of St. Paul, has accepted the invitation of Lieutenant-Colonel Rutherford, surgeon at Fort Snelling, to partake of an army mess and to hold the reunion at the

Fort, Tuesday evening, January 11. An informal discussion will be held on the possibility of organizing a Medical Officers Society of the Northwest.

MONTANA

Personal.—Dr. Dan J. Donohue, Butte, has been reappointed physician for Silver Bow County.

Hospital Staffs Appointed.—The board of directors of the Deaconess Hospital at Great Falls has appointed as members of the medical board the following physicians: Drs. Gowan Ferguson, Edward M. Larson, Leroy Southmayd, Earl Strain, Enoch M. Porter and C. C. Counter.——Drs. James H. Irwin, LeRoy Southmayd, William A. Hulbush, James B. Reynolds, Charles J. Bresee, Donald K. Woods, William J. Lakey, George Putney, Aloysius Dolan, Albert F. Longeway, James C. MacGregor and Donald A. McLennan have been appointed members of the advisory staff for Columbus Hospital, Great Falls.

NEW YORK

Mental Hygiene Clinic.—The department of health of Glens Falls has established a clinic in mental hygiene; the clinic will probably be conducted once every month.

Plattsburgh Votes Water Supply Funds.—The voters of Plattsburgh at a recent referendum approved an appropriation of $90,000 for the establishment of a chlorination plant and for extensions of the water supply system.

New York City

Personal.—Prof. Sutherland Simpson, Ithaca, has been appointed professor of physiology in the Ithaca Division of Cornell University.

Addition to Hospital.—Plans have been filed for an addition and alterations to the present Broad Street Hospital. The new building, located at 123 and 125 Broad Street with a frontage of 40 feet, will be erected at a cost of $300,000.

Home for Mental Convalescents.—A campaign is in progress to raise $50,000 to augment the building fund of the Home and Farm Institution for Mental Convalescents. It is planned to erect an institution on Long Island where the mentally afflicted may be restored to health and vigor through proper environment and treatment.

Police Oppose Hospital Plans.—New York policemen do not want the $5,000,000 hospital planned by Commissioner Enright and deputy commissioners, and the Patrolmen's Benevolent Association recently held a meeting to discuss the advisability of launching a department fight against it. It is claimed that there is not sufficient demand to warrant the expenditure of so large a sum, and that the patrolmen prefer to be taken to hospitals of their own selection. Orders have been issued discontinuing the solicitation of funds for such an institution.

NORTH CAROLINA

Officers of Mecklenburg Society.—At the December meeting of the Mecklenburg Medical Society the following officers were elected for 1921: president, Dr. John P. Munroe; vice president, Dr. Robert F. Leimbach, and secretary-treasurer, Dr. John L. Ranson (reelected), all of Charlotte.

OHIO

University Receives Rockefeller Foundation Grant.—The general education board of the Rockefeller Foundation has offered to contribute $700,000 to the Medical College of the University of Cincinnati, on condition that the balance of $400,000 to complete the $2,000,000 endowment fund be subscribed.

County Societies Elect Officers.—At the annual meeting of the Hancock County Medical Society the following were elected officers for the ensuing year: president, Dr. William J. Zopfi, Findlay (reelected); vice president, Dr. Alvin E. King, Mt. Cory; secretary, Dr. Nelia Kennedy, and treasurer, Dr. Earl J. Thomas, Findlay.——Greene County Medical Association, at its regular meeting, December 2, elected the following officers: president, Dr. William A. Galloway, Xenia; vice president, Dr. Frank W. Ogan, Jamestown, and secretary-treasurer, Dr. Clarence Hugh Denser, Columbus.

PENNSYLVANIA

Board of Health at York.—The city council of York has appointed the following members of the board of health: Drs. Martin L. Barshinger, Herman H. Farkas, and Homer D. Baird, Miss Anna M. L. Huber and J. Calvin Strayer.

County Societies Elect Officers.—At the annual meeting of the Somerset County Medical Society, held in Lakewood, the following officers were elected for the ensuing year: president, Dr. Charles B. Korns, Sipesville; vice president, Dr. Henry S. Kimmel, Somerset; secretary, Dr. Henry C. McKinley, Meyersdale, and treasurer, Dr. Carl W. Frantz, Confluence.——At the annual meeting of the Columbia County Medical Society held in Bloomsburg, December 8, Dr. Charles B. Yost, Bloomsburg, was elected president, and Dr. Luther B. Kline, Catawissa, secretary-treasurer.

Philadelphia

Wills Hospital Ophthalmic Society.—It is proposed to revive the meetings of the Wills Hospital Ophthalmic Society which were discontinued during the war. The first meeting will be held Tuesday, Jan. 4, 1921, at which cases from the clinics and wards will be exhibited and discussed.

Health Courses Planned in Schools.—The need for courses in health was discussed by Dr. Thomas E. Finegan, state superintendent of public instruction, at an educational meeting and reception at the Philoumusian Club. Good health is as necessary as good education and it is planned to give a course that will teach health from the first grade.

Personal.—Dr. Lester J. Unger, New York, addressed the section on general medicine of the College of Physicians of Philadelphia, December 13.——Dr. Lewis Webb Hill, Boston, delivered an address before the Philadelphia Pediatric Society, December 14, on "Nephritis in Childhood."——Dr. John H. W. Rhein has been appointed visiting physician to the psychopathic wards of the Philadelphia General Hospital.——Dr. Samuel D. Ingham has resigned as clinical professor of neurology in the School of Medicine of Temple University and has gone to Los Angeles to join a medical diagnostic unit.

WISCONSIN

Personal.—Dr. Charles E. Ide, Redlands, Calif., has been appointed superintendent of the Muirdale Sanatorium, to succeed Dr. Glenford L. Bellis, resigned.

New Tuberculosis Society.—The Washburn Tuberculosis Association was formed at a meeting held late in November and the following officers were elected: president, Dr. Bernard Schlossmann; vice president, Miss Anna Thompson, and secretary-treasurer, Rev. D. W. Davis.

County Society Elections.—At a meeting of the Fond du Lac County Medical Society, held December 8, the following officers were elected: president, Dr. Frank M. McGauley; vice president, Dr. David V. Meiklejohn, and secretary-treasurer, Dr. David N. Walters, all of Fond du Lac.

CANADA

Alberta Association Elects Officers.—At the annual meeting of the Alberta Medical Association, held at Edmonton, under the presidency of Dr. William F. Gershaw, Medicine Hat, the following were elected officers for 1921: president, Dr. Walter S. Galbraith, Lethbridge; vice presidents, Drs. Robert B. Wells, Edmonton, and Albert E. Archer, Lamont; secretary, Dr. John E. Palmer, Calgary, and treasurer, Dr. Fuller S. Macpherson, Edmonton.

Canadian Medical Association Journal.—For some months there has been in contemplation enlargement of the official organ of the Canadian Medical Association, and if the project receives ample support from the members of the association and the physicians in general, the organ will soon be published bimonthly, and eventually weekly. The editorial management is proceeding energetically despite the increasing costs of production and diminishing receipts from advertising and patronage. Since the official organ of the Ontario Medical Association, in existence for less than a year, has suspended publication, there will now be organized a separate editorial board for Ontario; the other provinces have also signified a willingness to render greater cooperation.

GENERAL

Physiologic Society Meeting.—The American Physiological Society will hold its annual meeting in Chicago, December 30.

Bacteriologists' Meeting.—The annual meeting of the Society of American Bacteriologists will be held in Chicago, December 28-30.

Rockefeller Foundation Program for Central Europe.—For the purpose of assisting medical schools in central Europe, the Rockefeller Foundation has announced a cooperative program embracing aid in procuring scientific equip-

ment for teaching and research, and in furnishing medical journals to universities throughout Europe. An invitation has been extended to the authorities of Belgrade University Medical School to study medical education in America and England, as guests of the Foundation. Dr. Frederick F. Russell, who has been serving as technical advisor in public health laboratory organization to the Czech Ministry of Hygiene since August, will arrange the details of the Foundation's program.

Sheppard-Towner Maternity Bill.—With material modifications from its original form, the Sheppard-Towner bill, which makes provision for maternity and infant welfare through Federal cooperation with the states, has been passed by the Senate. The bill appropriates $1,480,000, of which $10,000 is to be distributed annually to each state, and $1,000,000 is to be used annually by the Children's Bureau. During the three days' debate on the bill in the Senate the provision for home nursing at government expense was eleminated; an amendment was added that the members of the state advisory committees should not receive a salary, and is was stipulated that no part of the appropriation should go to any state until an amount equal to the sum to be supplied by the Federal Government had been appropriated from the state treasury.

The All-America Conference on Venereal Diseases.—The All-America Conference on Venereal Diseases, held in Washington, D. C., December 6-11, consisted of two bodies conducting some of their meetings independently, but cooperating throughout the session and holding joint meetings every evening. The first of the bodies, designated as the general conference committee, consisted of nearly 100. Its membership was selected by the president of the conference, Prof. William H. Welch, on nomination of the administrative committee. An attempt was made to choose those who would be able to discuss with authority certain phases of the many problems presented to the conference. So far as possible the administrative committee endeavored to secure representatives of divergent views on important questions to the end that all such questions should be fully discussed from various points of view. At the first meeting the conference was divided into twelve groups, each dealing with certain interrelated problems. These problems were presented to the various groups in the form of questions which had previously been prepared by the administrative committee and others. There were no set papers. At the conclusion of the conference authoritative answers in almost all of the various phases of the problem presented by the control of venereal diseases were given so far as this was possible.

The afternoon session was held as a committee of the whole and to this each section chairman reported the conclusions arrived at by his section in the morning meeting. These conclusions were reported in the form of resolutions presented to the entire conference committee and were then open to general discussion. In some instances conclusions presented by one section and sharply combated by members of another section were referred to a joint meeting of the respective sections and of such others as were interested with instructions to submit a report on the following day. In some instances conclusions presented to the general conference committee by one section were adopted with only minor verbal changes and in many instances the conclusions were adopted by the general conference committee unchanged. While these meetings were going on all the other delegates to the All-America Conference on Venereal Diseases assembled in meetings held in the auditorium of the New National Museum. These meetings were conducted under the auspices of the American Social Hygiene Association and consisted of formal papers followed by discussions and by the discussion of matters brought up by the delegates themselves. At some of these meetings resolutions were adopted for consideration by the general conference committee. An important feature of the conference was the evening meetings of delegates at the New National Museum at which the resolutions adopted in the afternoon by the general conference committee were presented for discussion and adoption. At these meetings an opportunity was given for still further change in the form of the resolutions presented and these changes having subsequently been approved by the general conference committee became the pronouncements of the All-America Conference on Venereal Diseases. Among the problems presented to the conference were:

Have we any evidence of the establishment of immunity to gonorrhea and syphilis?

Should the Wassermann test be standardized?

How should the Wassermann test be used in dealing with syphilis and to what extent should it be relied upon as evidence of syphilis in the absence of clinical symptoms.

In the treatment of syphilis what is the relative value of arsphenamin, neo-preparations, other arsenicals and non-arsenicals?

Is it scientifically and medically practicable to determine a standard for declaring that a case of gonorrhea is cured? If so, what criteria should be used?

What effective methods have we for treating gonorrhea in the female, vulvovaginitis in infants and young children?

What measures should be taken with persons stopping treatment before cure? While still in infective state?

What place has so-called "medical prophylaxis" in controlling venereal disease?

What methods of "medical prophylaxis," if any, have given evidence of practical utility?

On what basis, from a public health point of view, should the state attempt to govern the issuance of marriage licenses?

What are the relative advantages or disadvantages of having venereal disease clinics separate from other clinics?

Should cases of venereal disease be admitted to general hospitals? If so, what special facilities, if any, do they require?

Should all hospitals receiving any aid from the public funds be compelled to remove their present restrictions against the admission of the venereal patient, or not?

For informational purposes in venereal disease campaigns what statement does our present knowledge of syphilis justify in regard to its approximate relationship to

Prevalence in civil population?

Disability with resulting economical loss to industry and to families?

Cost to tax payers of caring for the end-results of insufficiently treated cases?

Is the appeal to fear of venereal diseases in pamphlets, motion pictures and other materials adequate? Is there danger of causing psychoses in using the appeal to fear of venereal diseases?

Is it possible to evaluate the effectiveness of various materials and measures used in educational work? If so, by what methods may we evaluate them and what is the relative value of pamphlets, placards, motion pictures, exhibits, lectures, magazine and newspaper advertising (paid) and magazine and newspaper articles (free publicity)?

What methods, if any, of instructing persons about to marry can be devised that will be effective and not subject to abuse?

Should fines ever be imposed on persons convicted of prostitution?

Are the reformatory methods used with prostitutes effective in relation to the control of venereal disease?

What practical modifications of existing methods of sex education should be made in view of our knowledge of the stages of sex development?

Is there any danger that increasing success of programs of repression of prostitution will bring about psychological or psychiatric damage through sex repression?

Is continence compatible with health?

It is not possible to present all of the resolutions adopted by the conference. Preparation of this material has been begun and should be available within a few months. The general form of the manner in which some of the questions have been answered is shown by the following resolutions adopted by the conference.

In reply to a question as to the establishment of immunity to gonorrhea and syphilis, the committee presented the following resolution:

"With reference to gonorrhea, there is no evidence of the establishment of any immunity to disease beyond that of a more or less temporary immunity in the case of existing, individual infections. Such a temporary relative immunity may be lost either as the result of disturbed relations between the infecting organism and the host or through the introduction of a new gonorrheal infection.

"With reference to syphilis there is no evidence of an absolute and permanent immunity to syphilis unless it be that due to an existent infection. There is evidence to show that infection may exist without obvious manifestations of the disease. The immunity ensuing in such an infection may extend even to the degree of a commensal or symbiotic adaptation."

With respect to the use of the Wassermann test, among other things, the following may be of interest:

"Resolved that: The blood Wassermann reaction should not be used as a sole guide to the duration of a syphilitic infection. The blood Wassermann reaction should not be used as the sole evidence of the effectiveness of a particular drug or method of treatment. The blood Wassermann reaction should not be used as the sole evidence of "cure" no matter how many times repeated."

Laboratory workers and clinicians may be interested in the following:

"Resolved that: The complement fixation test has not yet been shown to be of value in the diagnosis of doubtful cases of gonorrhea. It is possible, however, that the precipitin test recently reported by Meader and Robinson may be of great value."

The committee enumerated some of the advantages of having venereal disease clinics operated in conjunction with other clinics and pointed out that such a plan "promotes recognition by the public that venereal diseases are being dealt with exactly like other diseases." It also pointed out that under this plan "the treatment of venereal diseases in the same insti-

tution with other diseases promises a better understanding on the part of young physicians especially among interns and medical students regarding the importance of these diseases and of the true relation established between them and other pathological conditions."

In promoting education with respect to the venereal diseases, it was resolved that:

"Fear should not be deliberately stressed as a deterrent. The element of fear should appear only to the extent that it is inherent in the presentation of the facts themselves. Any morbid tendencies resulting from such unavoidable fear should be corrected by positive and constructive teaching as to the prevention and cure of the disease."

In dealing with law enforcement, it was resolved that:

"The establishment and maintenance of high standards of sex conduct is the best protection of public health from venereal diseases.

"That up to the level of the highest standards which can be sustained by public opinion, laws penalizing the promotion of and the indulgence in illicit sex relations constitute sound and practicable public health measures."

In dealing with sex offenders, it was resolved that:

"The establishment of reformatories with standard equipment for examination, classification, training, recreation and parole is the most hopeful method of rehabilitating the old offender."

The psychological aspect of the venereal disease problem, at least in one of its phases, was touched on in the following resolution:

"Resolved that: Although there is danger that a superficial and erroneous interpretation of the Freudian psychology in regard to the repression of the sex instinct may be detrimental to the successful development of the program for the control of venereal disease, a more thorough-going, complete and scientific interpretation, however, tends to aid such a program in that it places the emphasis upon the practical means for guiding the sex instinct into socially useful and constructive activities."

The committee emphasized the importance of social service, recreational facilities and measures for dealing with feeble-minded delinquents and a host of other questions.

In connection with the meetings of the All-America Conference, interesting exhibits and demonstrations were offered by the various interested institutions. Thus at the Hygienic Laboratory of the Public Health Service a demonstration of the method of the government control of arsphenamin was given. A demonstration of selected cases of syphilis in the government hospital for the insane was given by Dr. William A. White. A visit was paid to the Washington Police Station in order to observe the method of applying police functions to social hygiene. At the U. S. Naval Hospital, methods for the adequate treatment and diagnosis of syphilis and gonorrhea were demonstrated. In the Army Medical Museum there was a display of interesting wax models dealing with various phases of venereal disease and the library of the Surgeon-General had on view a special collection of books, manuscripts and other materials relating to venereal diseases. The American Social Hygiene Association exhibited a social hygiene field car used at present in conducting educational work in social hygiene in North Carolina. The U. S. Public Health Service showed a model clinic and an exhibit of placards and pictures used in its campaign against venereal diseases. In the new Navy Building the morale division displayed its exhibit dealing with venereal diseases.

Altogether the conference was attended by over 400 delegates, including representatives from Argentine, Brazil, Chile, Ecuador, Cuba, Honduras, Mexico, Paraguay, Porto Rico, Canada, Czecho-Slovakia and England.

The organization of the All-America Conference on Venereal Disease was in the hands of the following officers: president, William H. Welch; administrative committee, William F. Snow, chairman, Thomas A. Storey, C. C. Pierce, and Livingston Farrand; executive officer, Allen Winter; director of public information, Charles Bolduan, and treasurer, John Poole.

LATIN AMERICA

Personal.—Dr. A. B. Vasconcelos, the editor of the *Gaceta Médica de Mexico*, who represented his country at the All-America Conference on Venereal Diseases in Washington, is now visiting medical centers in this country, including Chicago.——Dr. T. G. Perrin, a noted Mexican bacteriologist, who also attended the same conference, has returned to his country.——Dr. C. Masi of Asunción, Paraguay, the Paraguayan delegate to the conference, expects to spend several months in this country to study medical matters.——Dr. E. E. Jumper of Torreón, Mexico, is taking a postgraduate course in Chicago.——Dr. P. García Medrano has been appointed acting Mexican consul to Chicago.

Meeting of Porto Rican Medical Association.—The Porto Rican Medical Association held its annual meeting at the Sport Club, Ponce, December 11-12, under the presidency of Dr. Pedro Malaret. Papers were presented on neurology by Dr. E. Font Guillot, San Juan, on the treatment of external tuberculosis by Dr. I. González Martínez, San Juan, on moniliasis by Dr. Bailey K. Ashford, San Juan, on sprue by Dr. P. Gutiérrez Igaravides, San Juan, on syphilis by Dr. M. Quevedo Báez, San Juan, renal fragility by Dr. Guillermo Salazar, Ponce, and on surgery in Porto Rico by Dr. Jorge del Toro, San Juan.

Sale of Certain Nostrum Forbidden in Buenos Aires.—The *Semana Medica* of Buenos Aires relates that the public health service of the province of Buenos Aires has officially forbidden the sale of Radiosol Vegetal throughout the province, claiming that it is practically merely tap water, not conforming to the published formula. Our exchange extols this action of the provincial Consejo de Higiene, under the heading "A Lesson for the National Public Health Service," continuing, "While the provincial public health service is thus arresting the sale of a quack nostrum, the national public health service, the chief institution in the land, with culpable silence is allowing advertising and sale of a numerous series of pharmaceutic products which are nothing but preparations of narcotic drugs, prepared with the most elementary therapeutic indications, when they are not directly harmful. . . ." "At the same time the Departamento Nacional de Higiene, forgetting thus deplorably its task of watching over and safeguarding the public health, is consenting to the sale of certain specifics at fabulous prices, such as certain foreign vaccines which are being most unconscionably exploited by profiteers."

FOREIGN

The Legendre Prize.—A prize has been endowed in the name of Dr. Paul Legendre at the Société médicale des hôpitaux de Paris to confer 3,000 francs every third year on the best work on the ethical and social aspects of the medical profession, published or presented during the preceding years, or for the best competing articles presented on a special topic. The first prize will be awarded in December, 1923, and a topic has been selected for this competition, namely, "A statistical and critical study of the French civilian and military medical and surgical rôle during the war, 1914-1918, and the resulting consequences for physicians and conclusions for the future."

Institution to Investigate Pharmaceuticals Proposed in Germany.—The *Medizinische Klinik* brings word that the commission appointed years ago by the organized German internists, the Arzneimittel-Kommission, has been transformed to found an institution to investigate new pharmaceutical articles and supply information thereon to physicians on demand. An information bureau and bibliographic center is planned, and it is proposed to test new inventions for the manufacturers. This will not be necessary for the larger manufacturers, as they are well equipped for the purpose, but it will apply to the products of less thoroughly standardized makers and to remedies of doubtful value. "The members of the commission say that they are well aware of the extremely difficult and responsible task which they are undertaking, and realizing this to the full, they have decided not to restrict their investigations to the chemical, pharmaceutical and pharmacologic side of the matter, but in given cases will conduct tests and investigations at the bedside to decide on the harmfulness of the article. . . ." "With this program," the editorial continues, "the task undertaken goes far beyond that of the Council on Pharmacy and Chemistry of the American Medical Association, which limits its work to the chemical analysis of the proprietaries and nostrums which are so numerous and are advertised on such large scale in North America. It may well be questioned whether it would not be better to restrict the work to the purely chemical and pharmacologic analysis. Even this limited field represents a mighty task for the institution that is being founded. . . ." "It has been decided to accept the offer of the Berlin Pharmakologische Universitätsinstitut, in charge of Heffter, to make this the headquarters of the new prüfungsamt. Considerable funds will be needed to call into existence an institution planned on such a comprehensive scale and with so many fields of work. Adequate subsidies from without cannot be expected. Hence, it is planned to appeal to German physicians and urge them to contribute to this purpose. The aim is to create an institution to advise and guide the physician in the choice and criticism of new remedies. The efforts of the Arzneimittel-Kommission should be regarded with grate-

ful appreciation. This appreciation will be all the greater if they succeed in working the rather unmalleable material into a living organism. The former efforts in this line have not been very encouraging. The newly founded institution will certainly understand how to profit by the lessons of former experience, and to outline its work in a correct and efficient manner. . . ." It is hoped that each German physician will give at least 10 marks toward the organization fund.

Deaths in Other Countries

Barão de Pedro Affonso, professor of surgery at Rio de Janeiro for twenty-five years, and long director of the Rio public health service, aged 75. The introduction of vaccine lymph for smallpox, the vaccine institute, and the institute for preparing antiplague serum, to which he called Oswaldo Cruz, were fruits of his efforts.——Dr. **R. Vidart,** member of the Argentina lower house, from the province of Córdoba, aged 43. ——Dr. **J. Cuesta** one of the victims of influenza which is said to have reappeared in the Almeria region, Spain.——Dr. **Boset,** one of the leading physicians in Luxembourg.——Dr. **R. Zeri,** director of the Italian hospital at Constantinople.—— Dr. **W. Schütz,** professor of pathologic anatomy at the Berlin veterinary college, and a pioneer in the study of diseases of domestic animals.——Dr. **Hugo Ribbert,** professor of pathologic anatomy at the University of Bonn and a prolific writer on pathology and histology, aged 65.——Dr. **Sabouria,** chief of the sanatorium at Durtol, France, and author of works on pulmonary tuberculosis.——Dr. **Alvaro Graça,** for a time sanitary inspector at Rio de Janeiro.

Government Services

Reserve Officers' Training Unit

An application has been received at the Army Medical Corps headquarters from the University of Minnesota Medical School for the establishment of a reserve officers' training unit. The enrolment of the necessary fifty students has been completed in accordance with the Army Reorganization Act, and an officer will be assigned to the university at once to inaugurate the course for the training of reserve officers.

Inquiry Into Walter Reed Hospital Fire

The destruction of two frame wards at the Walter Reed Hospital by a fire which caused the death of a former soldier suffering with mental disorder has resulted in independent investigations by Congress and the War Department. It is expected that Congress will grant the necessary appropriations to complete the Walter Reed Hospital and to abolish all wooden structures where patients are now being housed under perilous conditions.

Special Hospital for Disabled Soldiers

Senator Wadsworth of New York has introduced a resolution in the senate authorizing the Treasury Department to lease from New York state a $3,000,000 hospital for the care of nervous and mental cases among disabled soldiers. The resolution proposes to place the hospital under the jurisdiction of the Public Health Service, and gives the Treasury Department authority to lease any other hospitals built for similar purposes by other states of the Union.

Hospital Facilities for War Risk Patients

In its annual report to Congress the Public Health Service requests appropriations to provide additional hospital facilities to meet the growing needs in connection with the care and treatment of Bureau of War Risk Insurance beneficiaries. The report shows that 20,000 patients are under treatment this year, in comparison with 2,000 last year, and attention is called to the fact that many of the hospitals are in a dilapidated and unsatisfactory condition. It is proposed to put these in good condition, and to reconstruct antiquated structures.

Precautions Against Introduction of Epidemic Diseases

Restriction of commerce during the war prevented the spread of typhus, plague and cholera, which were prevalent in countries of central Europe, but since the resumption of commercial intercourse these diseases have again begun to invade neighboring countries. Precautions have been taken by the Public Health Service to prevent importation of epidemic diseases into the United States, and officers have been stationed at practically all the important ports of Europe to inspect vessels and their crews and passengers prior to their departure for American ports. Stringent measures have also been adopted along the Mexican border to prevent the introduction of typhus fever.

Coordination of Government Activities

The Smoot-Reavis resolution, which has passed both houses of Congress, provides for a survey of the administrative services of the government, to study their powers and duties, and overlapping and duplication of authority, and to determine what redistribution should be made for proper correlation of the efforts of executive departments. If approved by the President this measure will permit hearings to be held for the purpose of consolidating certain medical activities of the government, and to secure greater economy in the functions of the Public Health Service, the medical departments of the Army and Navy, the Interdepartmental Social Hygiene Board, Children's Bureau and Women's Bureau.

Foreign Letters

LONDON

(From Our Regular Correspondent)

Nov. 29, 1920.

Dependents' Right to Compensation for Workman's Suicide

Attention has often been drawn in previous letters to the breadth of the Workman's Compensation Act which renders an employer liable for accidents arising to a workman "in or out of his employment." The latest application of the act establishes the precedent that the employer may become liable to the dependents for the suicide of a workman. The case came before the court of appeal to decide whether the dependents of a workman who had committed suicide through mental depression, as the result of an accident, could recover compensation. The workman, a miner, received a severe injury to the hand, Nov. 17, 1919. He suffered great pain and was much affected in his spirits by the accident, informing his wife that he knew that his hand would never be right again. He was paid compensation until February 11, but during the whole time was in a depressed condition and suffered from insomnia. About February 15, his physician advised him to return to work and endeavor to shake off the depression. He did so, but came back in the evening greatly worried by his inability to carry on as before the accident. February 28, he committed suicide. On a claim for compensation, the evidence of the physician was that his mind was perturbed by the accident; that the perturbation became worse, and that the condition was neurotic. A specialist deposed that he had not seen the workman, but from the facts submitted to him he judged that he was suffering from insanity. In his opinion the accident had given the man a shock, and the shock and suffering had resulted in melancholia, which had been the first stage of insanity. The judge found that the workman committed suicide by reason of the insanity resulting from the accident, and awarded compensation. The employers now appealed.

The master of the rolls (the president of the court of appeal) in giving judgment said that to justify a finding of the sort it must be shown that the suicide was the result of the accident and not a result of the brooding over the injury received. In other words, it must result from the injury and not from the state of mind caused by the injury. Further, it must be remembered that the question was not whether the judge of the lower court was right but whether

there was evidence on which he could find as he did. It seemed to him that there was distinct evidence of a mental shock which was followed by melancholia, a progressive state of things which went on until it culminated in insanity. Now, a mental shock, if sufficiently serious in its effects, might be the subject of compensation although there was no actual physical or structural injury; and without saying what he (his lordship) might himself have found, there clearly was evidence on which the judge could have found that the melancholia arose through the shock of the accident and not merely through the man's mind brooding over the accident. If there was evidence of that, there would be the authority of Lord Cozens-Hardy in deciding a previous case that that would be ground for compensation. That judge said: "It has been said that there is some doubt whether suicide can be the result of an accident within the Workman's Compensation Act. I confess I do not feel that doubt at all. I have no doubt that it may be an accident of such a nature that there is a lesion of the brain, a structural injury to the brain itself, which accident may lead to unsoundness of mind, which may directly lead to suicide." When once established that the shock and suffering of the accident, without any structural injury, might give rise to right to compensation, it could not be said that the judge of the lower court had no grounds for deciding as he did. The appeal must therefore be dismissed. The other judges of the court of appeal (Lord Justices Warrington and Scrutton) delivered judgment to the same effect.

Breeding from the Worst Stocks

The dean of St. Paul's, Dr. Inge, is well known for his fearless and outspoken, as well as philosophical utterances on questions of the day. For the Eugenics Education Society he has delivered an address on "Eugenics and Religion." He said that little interest was taken in the subject in religious circles, and the notion that it was part of our duty to think of the physical, intellectual, and moral improvement of the human stock was still strange to the vast majority. Nevertheless, religious people were willing to accept eugenic principles provided they were fortified by long tradition. The prejudice against the marriage of first cousins, whether well or ill founded, was accepted as readily by religious as by irreligious persons, and if a similar tradition were established against the marriage of deaf mutes and epileptics there would be no opposition on the part of the churches. If religion were their enemy they would find an active enthusiasm for eugenics in those large sections of society which were not directly influenced by religious traditions. For example, they would find politicians taking some interest in race improvement. But notoriously they took none whatever. The enemy of eugenics was not religion, but the antiscientific temper.

The Prophylaxis of Venereal Disease

The problem of venereal disease still continues to attract a good deal of attention. The National Birth Rate Commission has appointed a committee consisting of prominent men in the churches and the medical profession, including Sir Arbuthnot Lane, Sir F. W. Mott, Sir H. D. Rolleston and Sir G. Sims Woodhead, to consider the questions: 1. Whether sexual continence before marriage is consistent with normal health. 2. Whether self-disinfection as a method of preventing the development of venereal disease in persons who have exposed themselves to the risk of infection is more efficient or less efficient than medical treatment at venereal clinics and early treatment centers. 3. The possible advantages and disadvantages of the various suggested methods of disinfection (*a*) before and (*b*) after sexual intercourse. 4. Whether methods of self-disinfection involve any serious disadvantages of a moral kind—that is to say, whether they are calculated to weaken moral control, and thereby lead to an increase in promiscuous sexual intercourse. 5. If so, to what extent these disadvanages should render the use and advocacy of self-disinfection undesirable when considered from the point of view of ultimate national welfare.

The Axolotl Changed Into a Salamander by Thyroid Feeding

The occasional change of a Mexican axolotl, a purely aquatic newt breathing by gills, into the ambystoma, a terrestrial salamander, with spotted skin, breathing by lungs, has long been known. The animal usually breeds in the axolotl stage and misses out the final stage in its life history. By placing it on damp moss for an increasing time every day, the final transformation has been artificially induced. More recently the discovery has been made that feeding the axolotl on thyroid gland produces the metamorphosis very quickly, even if the axolotl is kept in water. In the reptile house at the Zoological Gardens, full-grown examples of the common black axolotl and the pretty white variety are exhibited. Some are nearly 3 inches long. Alongside are shown several examples of the ambystoma stage, produced in the laboratory of the Oxford University and at the gardens by thyroid feeding. These are all of the white variety. These ambystomas are much paler than the normal form, but are spotted to a certain extent. What is more remarkable is their very small size. When the metamorphosis is produced by other methods, or occurs spontaneously, the change takes place in well grown axolotls. Thyroid gland has the same effect on axolotls a little more than an inch long.

PARIS

(From Our Regular Correspondent)

Nov. 19, 1920.

The Poison Act

The poison act, which was passed in 1916, has given rise to numerous protests and lively criticisms. It is becoming more apparent every day that the law works greater hardship on the sick than on the opium smokers and cocain habitués, for in the absence of international agreements on the subject, the addicts can readily satisfy their craving by procuring supplies in nearby foreign countries. Dr. Perrin of Nancy lately presented further criticism before the Société française de prophylaxie sanitaire et morale, claiming that the law was a serious obstacle in the ambulatory treatment of syphilis.

In France the classic ambulatory treatment of syphilis includes the administration of Dupuytren's pills or Ricord's pills, both of which contain a small amount of opium to correct the intestinal irritation caused by the mercuric chlorid or protiodid. The Codex français of 1908 gives the composition of Dupuytren's pills as mercuric chlorid, 0.01 gm., and extract of opium, 0.02 gm., and of Ricord's pills as mercuric chlorid, 0.05 gm., and powdered opium, 0.02 gm. In the majority of syphilis clinics it is customary to give the patient a blanket prescription for these pills with directions that they take two pills daily at meals on twenty consecutive days should they find it impossible to report regularly for the mercurial or arsenic injections, or as an adjuvant between the series of injections. This course is to be repeated monthly during the first year, bimonthly during the next, and quarterly during the third and fourth years.

Under the act of July 12, 1916, it is no longer possible to prescribe Dupuytren's or Ricord's pills. In fact, the regulations defining the application of the law prohibit the prescribing of any preparation of opium for more than seven days, except in cases in which the total amount of extract of opium does not exceed 0.12 gm. Even though the physician should

prescribe the customary dose for a twenty days' course, the druggist must decline to fill the prescription on the threat of incurring a penalty of a fine of from 1,000 to 10,000 francs, and imprisonment for from three months to two years. A physician can, of course, give a renewable prescription for six Dupuytren's pills, but it is difficult to conceive that the syphilitics, who as a rule are inclined to neglect systematic treatment even in the absence of vexatious difficulties, will submit to a course which forces them to renew their supply of pills once or twice a week. Besides this, they must always go to the same druggist, for the latter is obliged to preserve the prescription for three years. One of the principal advantages of these pills is that they are convenient to carry and easy to take even on a journey, a matter of importance to the great number of syphilitics whose occupation forces continuous travel, as commercial travelers, for instance.

Still greater difficulty is occasioned by another regulation which compels the patient to enter his name, occupation and address in a special register kept by the druggist. This requirement destroys the confidential relation which is absolutely indispensable from every point of view.

These criticisms were brought to the attention of the Académie de médecine, and on motion of Dr. Siredey, it was resolved (1) that the regulations of Sept. 14, 1916, dealing with the sale of poisonous substances cease to be applicable to mercurial preparations containing opium, and that the physician be permitted to prescribe at one time a sufficient quantity of such preparations to last for a four weeks' course of treatment; (2) that the practice of inscribing the name and address of the patient in a special register be discontinued in connection with those medicines that of themselves suggest the nature of the disease and that, instead, the name of the physician be entered; (3) that the druggist be authorized in entering prescriptions containing antisyphilitic remedies to substitute for mercury the word hydrargyrum or its chemical symbol, or, better still, the number of the prescription, and (4) that a complete revision of the regulations be undertaken with the least possible delay, as some of the requirements are incompatible with the exigencies of medical practice.

VIENNA

(From Our Regular Correspondent)

Nov. 24, 1920.

Midwives in Austria

In the course of preparing new regulations for the midwives in this country, statistical data were collected from which it appears that there are in Austria about as many midwives as physicians, or even more, viz., 6,500 against 6,006 physicians for a population of about 6,225,000. The distribution, however, of these "wise women" is most unsatisfactory. While in cities and towns their numbers are more than plentiful, the country districts are insufficiently provided with midwives. It is the more to be regretted that qualified midwives flock together in towns and cities, because there the physicians are also called to attend normal childbirths, so that on an average not more than from thirty to forty cases fall yearly into the domain of each midwife. The figures vary between twenty-one in Vienna, thirty in Graz, and fifty-eight in Innsbruck. In the country districts the figures are even lower; a great number, if not the majority, of births are attended not by the qualified midwife but by a more or less benevolent old woman. This produces undesirable results both to the family and to the public health. The new "Midwives Act" now in preparation provides for the regular employment by the municipality, local board or country council of one duly qualified midwife for each 2,000 inhabitants. Such a distribution would mean about sixty births per year to each midwife, a figure corresponding to the present average birth rate in the country and sufficient to keep the women busy. At the same time a fee is fixed for each labor, varying according to the economic position of the family and the work and time required. As only 3,000 women would thus be recipients of a fixed salary—these would have to go out into the country—the remainder, over 3,000, would have to find their living as hitherto in the towns or change their occupation. It may be added that among the instructions issued to the midwife and already in force, the care of the eyes of the newly born infant occupies a prominent part. Each midwife is therein ordered to instill into the eyes of the baby two drops of a 1 per cent. solution of silver acetate, explaining to the family the reason for so doing. If the family objects to it, the midwife is bound to report the fact within twenty-four hours to the local board of health. Gonorrhea is very prevalent here as a sequel of the war. The midwife has to record on the card of notification of birth whether she has instilled the drops or not, in the latter case stating why she did not do so.

The "Yellow Cross" System of Medical Insurance

The increasing pauperization of the middle classes in this country is a real menace to the development or even existence of an independent medical profession, especially as there is a distinct tendency on the part of the government to turn the physician into a public health officer. Thus it gave great satisfaction that a plan brought into existence by a private corporation was adopted by the medical organization and promoted on a large scale. The principal features of this plan are as follows: The "Yellow Cross"—a society originally founded for the purpose of insuring its members, chiefly public and civil service officers, against illness—undertakes to pay its members, in case of severe illness or operation, a certain sum of money, varying according to the nature of the illness, but generally sufficient to meet moderate expenses. The insured is at liberty to choose his own physician. A minimum insurance of 3,000 kronen can be secured for monthly or yearly premiums, but one may be insured for two or more of these "units" by a proportionate increase of the premiums. If a person who is insured for two "units" has to undergo an operation for appendicitis or mastoiditis, he can choose his own surgeon and be received in any hospital or surgical home he may fancy. The surgeon's fee together with the hospital costs up to 6,000 kronen (two units) are paid by the "Yellow Cross." If the expenses run up to more, the patient must pay the difference. Now the income of a middle class man amounts to about 60,000 or 70,000 kronen a year. Only few of the brain workers, except several with independent means, earn anything approaching 100,000 kronen. Surgical operations cost between 2,000 and 10,000 kronen, and a two weeks' stay in a home or hospital costs from 4,000 to 10,000 kronen. Thus a protracted illness or operation would either spell ruin for the average man if it were to consume from 15 to 25 per cent. of his annual income, or it would force him to go to a public hospital. In the latter event, however, he cannot choose the physician in whom he confides and cannot find the comfort or quiet surroundings to which people of the middle class are accustomed. If, however, he is insured against such an eventuality, he has either no extra expenses or he may have to pay 2,000 or 3,000 kronen, which sum is not too great a burden for him. The premiums are moderate. The system offers, in fact, the only means for the practitioner to retain his patients. It keeps patients from drifting into the dispensaries and public hospitals, because they can continue to call their physicians in spite of the rise of fees generally adopted. The "Yellow Cross" has made arrangements to extend the benefits of its insurance to the members of the professions, artists, and teachers, in short, to all classes of the population not bound by law to belong to a "sick club" or krankenkasse. As the prosperity of this society is earnestly

to be desired, the medical organization of Vienna decided to enter it corporatively, and urged its members to induce their patients to join by explaining the advantages of the society.

Surplus of Women of Marriageable Age

The census of population taken Jan. 31, 1920, shows that the number of females has markedly increased, both absolutely and relatively, and in all age groups. There are 1,087 females for every thousand males in the whole of Austria, but for Vienna alone the figures are 1,163 to 1,000, an increase of seventy-seven males as compared to 1910. But if we take into consideration only those persons classed as of a marriageable age—all unmarried females or males over 19 years—we get quite a different aspect. In Vienna we find 1,413 females to 1,000 males at present, whereas ten years ago it was 1,227 to 1,000. In the rural districts the picture is not so appalling, but even there the ratio is never under 1,100 to 1,000, meaning that fully one tenth of the females cannot hope to marry. Very striking is the change in the industrial and mining districts of our country. While in 1910 there was in these places a distinct surplus of males, now the females outnumber their mates by from 42 to 117 per thousand. In the purely agricultural districts the difference is not so pronounced. Even in peace times there was an excess of females, 1,153 to 1,000, which has risen to 1,262 to 1,000.

Hypnotic Suggestion and Crime

Professor Wagner, director of the Vienna clinic for mental diseases, was recently the object of a startling experiment. A girl called at his office and handed him a letter pretended to be written by her medical adviser. While reading the letter, he suddenly noticed that the visitor leveled a revolver at his head. However, the woman dropped the weapon without firing. She was handed over to the police in a state of complete indifference, and nothing could be gotten out of her. At 10 a. m. on the next day she suddenly awoke from what seemed to be a hypnotic sleep, and gave correct answers to all questions. On the same day there appeared in the papers a letter in which a certain man explained that he had put the girl under hypnotic suggestion that Professor Wagner was responsible for the death of her fiancé and that she should take vengeance on the "murderer." He had also provided her with the pistol but had taken care to make it absolutely unfit for doing harm and had ordered his medium not to shoot at the professor, but simply to aim at him and to awake next day at 10 a. m. All this he did because the professor staunchly adhered to the opinion that it is impossible to make a person commit a crime while under hypnotic influence. The professor was taken completely unawares and the crime could have been committed, if so ordered. The incident brought the hypnotist into the police court. The professor maintains that the whole thing was a bluff because a crime is impossible. The opposing faction contends that the crime was averted only by the strict order of the hypnotist. The police will stop all public performances of this kind. Only scientific researches by competent men will be permitted hereafter.

Marriages

HENRY M. VAN HOOK, Mount Pulaski, Ill., to Miss Bessie Scroggin of Lincoln, Ill., November 19.

WILLIAM C. VANDIVER, Mena, Ark., to Miss Iva Conseer of Lequire, Okla., December 3.

HENRY SIMONS to Señorita Maria Cristina Quiroz, both of Colon, R. P., November 27.

WALTER FALKE JONES to Miss Marguerite Martini, both of New York, December 4.

Deaths

Nathan Smith Davis ● Chicago, son of the illustrious founder of the American Medical Association, died in California, December 21, after a long illness from lymphosarcoma, aged 62. Dr. Davis was graduated from the Chicago Medical College in 1883, and early began a teaching career as associate professor of pathology in his alma mater, holding this position from 1884 to 1886. He later became professor of the principles and practice of medicine and clinical medicine in the Northwestern University Medical School which succeeded the old Chicago Medical College. For some years he served also as dean. In association with his teaching position he was attending physician to Mercy, Wesley and St. Luke's hospitals. Dr. Davis showed great interest in the improving of the pharmacopeia, acting as vice president of the U. S. Pharmacopeial Convention, 1910-1920, and contributing many articles to medical literature on this subject. He served the American Medical Association in several capacities, acting as secretary of the Section on Practice of Medicine in 1887, as chairman of the Section on Pharmacology and Therapeutics in 1900, and as a member of the House of Delegates in 1902 and 1903. His interests were broad, including membership in the Ninth International Medical Congress and Pan American Congress, several offices in the Illinois State Medical Society, chairmanship of the board of scientific governors of the Chicago Academy of Sciences, and membership in the Chicago Neurological Society, the Chicago Pathological Society and the Institute of Medicine of Chicago. Several years ago, failing health compelled his retirement from practice and ultimately necessitated removal of his residence from Chicago to California. However, even during his declining years he kept up an active interest in medical progress.

Hyman Climenko ● New York; Long Island College Hospital, 1904; aged 45; chief of the neurologic clinic of Mount Sinai Hospital, and attending neurologist at the Neurological Institute, Beth Moses, Central Neurological, Beth David, Brownsville and East New York hospitals, died, December 16, following an abdominal operation.

William Park Mills ● Missoula, Mont.; Bellevue Hospital Medical College, 1879; aged 63; president of the Medical Association of Montana in 1913; for many years a member and one time president of the Montana State Board of Medical Examiners; died, December 6, from pneumonia.

Richard A. Pyles, Washington, D. C.; George Washington University, Washington, D. C., 1883; aged 58; a member of the Medical Society of the District of Columbia; a veteran of the Spanish-American War; died, December 5, from heart disease.

Charles H. Raley, Wrens, Ga.; University of Georgia, Augusta, 1883; aged 67; local surgeon for the Georgia and Florida Railroad; was instantly killed, November 30, when he was struck by a passenger train while crossing a railroad track.

Alfred Eugene Spalding ● Luverne, Minn.; Jefferson Medical College, 1874; aged 69; local surgeon for the Chicago, Rock Island and Pacific, and Chicago, St. Paul, Minneapolis and Omaha railroads; died, December 4, from pneumonia.

Enos C. Kinsman, Saginaw, Mich.; Chicago Homeopathic Medical College, 1895; aged 66; a member of the board of health of Saginaw; local surgeon for the Pere Marquette and Michigan Central railroads; died, December 5.

Richard Shepard Bryan, St. Louis; Washington University, St. Louis, 1897; aged 50; a member of the Missouri State Medical Association; captain, M. C., U. S. Army, and discharged, Dec. 31, 1918; died, December 7.

John W. Hanna, Winfield, Iowa; State University of Iowa, Iowa City, 1873; aged 73; at one time mayor of Winfield; for forty years local surgeon of the Burlington Railroad; died, December 2, from cerebral hemorrhage.

Robert Wade Brown, Washington, D. C.; Howard University, Washington, 1891; aged 58; a colored practitioner, visiting physician to Freedman's Hospital; was shot and killed at his home, November 27.

David Gordon, Chillicothe, Mo.; University of Louisville, Ky., 1877; aged 70; a member of the Missouri State Medical Association; for two terms mayor of Chillicothe; died, October 6, from cerebral hemorrhage.

Byron E. Dixon, Texarkana, Ark.; Marquette University, Milwaukee, 1913; aged 35; a member of the Arkansas Med-

● Indicates "Fellow" of the American Medical Association.

ical Society; died, December 6, from a self-inflicted gunshot wound of the head.

James Barrow, Bristol, Tenn.; University of Pennsylvania, Philadelphia, 1919; aged 27; surgeon at the Government Hospital, Ancon; died in that institution, December 5, from cirrhosis of the liver.

Joseph Edwin Hite, Kansas, Ill.; University of Pennsylvania, 1885; aged 62; for thirty years a practitioner of Kansas; died suddenly, December 4, from organic heart disease.

William J. Burnett, Long Island City and Woodmere, N. Y.; Detroit Medical College, 1869; aged 77; a member of the Medical Society of the State of New York; died, December 6.

Edward Moore, Colorado Springs, Colo.; St. Louis University School of Medicine, 1905; aged 44; a member of the Colorado Medical Society; died at Monrovia, Calif., November 23.

Kathryn Lorigan Devlin, Pittsburgh; University of Bishop College Faculty of Medicine, Montreal, 1897; for nine years medical inspector in the public schools; died, December 4.

John H. Ferguson ● Colorado Springs, Colo.; College of Physicians and Surgeons, Keokuk, Iowa, 1880; aged 67; died suddenly, December 4, from cerebral hemorrhage.

Vincent D. Lockhart, Maysville, Ga.; Atlanta (Ga.) Medical College, 1871; aged 71; died, at the Hardman Sanatorium, Commerce, Ga., November 14, from carcinoma.

Charles M. Hamilton, Holdenville, Okla.; University of Vermont, Burlington, 1877; aged 64; also a druggist; died, November 15, from cerebral hemorrhage.

Simeon I. I. Battiste, Louisville; Louisville National Medical College, 1898; aged 60; a colored practitioner; died, December 4, from cerebral hemorrhage.

Cyrus M. Stewart, Memphis, Tenn.; Memphis Hospital Medical College, 1883; aged 89; a veteran of the Civil War; died, December 6, from pneumonia.

L. P. Harrington, Waynesboro, Ga.; University of Georgia, Augusta, 1884; aged 60; a member of the Medical Association of Georgia; died, November 6.

Forrest L. Lightfoot, Cloverport, Ky.; St. Loius College of Physicians and Surgeons, 1898; aged 44; died, December 6, from heart disease.

George Clarence Horne, Black River Falls, Wis.; University of Vermont, Burlington, 1886; aged 60; died, November 28, from heart disease.

Edwin S. McDonald, Cameron, Mo.; Northwestern Medical College, St. Joseph, 1882; aged 71; died suddenly, recently, from angina pectoris.

William M. L. Weills, Harrisburg, Pa.; Long Island College Hospital, Brooklyn, 1870; aged 81; also a druggist; died, December 8.

Samuel Corley, Clarksville, Texas; University of Louisville, Ky., 1888; aged 57; died, November 27, from cerebral hemorrhage.

Charles B. Miller, Somers, Mont.; Medical College of Ohio, Cincinnati, 1867; aged 77; a veteran of the Civil War; died, December 1.

Edward F. Backmann, Philadelphia; Jefferson Medical College, Philadelphia, 1890; aged 60; died, December 6, from diabetes.

Frank Ring ● St. Louis; St. Louis College of Physicians and Surgeons, 1892; aged 65; died, November 19, from endocarditis.

Gustav G. Brudi ● New Haven, Ind.; Toledo (Ohio) Medical College, 1886; aged 57; died, December 6, from heart disease.

Angelo Orin Squier ● Springfield, Mass.; Long Island College Hospital, 1876; aged 66; died suddenly, November 18.

George Wensel Padiera ● Rochester, N. Y.; University of Breslau, Germany, 1864; aged 83; died, December 2.

John M. Duvall ● Springfield, Md.; Baltimore University School of Medicine, 1894; died, December 3.

Jeremiah D. Donovan, Lovington, Ill.; University of Louisville, Ky., 1868; aged 84; died, December 6.

C. C. Brown, Chickalah, Ark.; University of Nashville, Tenn., 1875; aged 74; died, December 1.

John D. De Liguori, Waterbury, Conn. (License, Connecticut, 1893); aged 74; died, November 2.

Henry L. Bollman, Robesonia, Pa.; Jefferson Medical College, 1885; aged 58; died, December 9.

Correspondence

THE QUESTION OF POSITIVE WASSERMANN REACTIONS CAUSED BY THE INTRAVENOUS ADMINISTRATION OF ARSPHENAMIN

To the Editor:—In the recent paper by Strickler, Munson and Sidlick (THE JOURNAL, Nov. 27, 1920, p. 1488), evidence was presented tending to show that the administration of arsphenamin to nonsyphilitic human beings may result in such changes that the serum yields positive Wassermann reactions. If these findings are correct and receive confirmation, new light and an entirely different interpretation are thrown on the provocative Wassermann reaction; furthermore and of much greater significance, the Wassermann reaction cannot be used as a serologic guide to treatment. The questions raised by this report are worthy of further study.

If the administration of arsphenamin to nonsyphilitic persons results in changing the serum from Wassermann negative to Wassermann positive, a similar change can reasonably be expected to occur among persons infected with syphilis; yet the great preponderance of evidence indicates conclusively that the serum of syphilitic patients gradually becomes Wassermann negative under treatment with arsphenamin or neo-arsphenamin, with or without mercury. Of course, the amount of treatment required before the serum of a syphilitic is changed from a positive to a negative reaction varies with the technic of the Wassermann test and especially according to the sensitiveness of the antigens employed; these variations directly concern the technic of the Wassermann test without affecting the widely adopted belief that under specific treatment the strength of the Wassermann reaction with the serum of syphilitic persons, is gradually reduced. Exceptions occur, and it is well known that the serum of a small percentage of syphilitics yields persistently positive Wassermann reactions despite vigorous and prolonged treatment; these "Wassermann fast" persons frequently show evidences of syphilitic involvement of the tissues of the central nervous system, and constitute a group requiring intermittent observation and treatment and further investigation bearing on our methods of treatment of syphilis.

While there is a divergence of opinion regarding the practical value of the provocative Wassermann reaction, I am sure that syphilographers have frequently noted an increase of the strength of the Wassermann reaction after the institution of treatment with arsphenamin and other antisyphilitic drugs; in other words, the serum of a person with latent syphilis giving a weakly positive reaction before treatment may yield stronger reactions after treatment has begun, constituting a "serologic Herzheimer reaction" and occasionally accompanied by an exacerbation of the symptoms of the disease. So far as the Wassermann reactions are concerned under these circumstances, I know of no reason for doubting that their enhanced strength is due to the influence of the drugs on increasing the activity of *Spirochaeta pallida.*

Furthermore, it is commonly believed that the serum of a syphilitic may give a negative Wassermann reaction if tested during or immediately after an intensive course of treatment with the arsphenamins or mercurials, whereas positive reactions may be observed after cessation of treatment for a period of two weeks or more; according to the report of Dr. Strickler and his colleagues, just the reverse would be expected. As a matter of fact, I have occasionally observed that the serum of some syphilitic patients may yield stronger reactions when tested during or immediately after an inten-

sive course of treatment with the arsphenamins than after a period of rest; this may be due to the influence of arsphenamin alone, as reported by Dr. Strickler and his colleagues in a large percentage of nonsyphilitics; but, on the other hand, it may be due to the presence of the reagin responsible for the Wassermann reaction in syphilis and frambesia, which gradually disappears after the destruction of spirochetes and the cessation of treatment.

Test tube experiments which I have conducted show that the mere addition of arsphenamin and neo-arsphenamin to normal human serum does not result in changes producing positive Wassermann reactions. The addition of 0.005 gm. or more arsphenamin to 0.2 c.c. of normal or syphilitic serum renders the latter strongly hemolytic; the addition of from 0.001 to 0.0003 gm. of arsphenamin and from 0.0006 to 0.0002 gm. of neo-arsphenamin renders a serum anticomplementary in tests conducted with 1 c.c. of 1:20 guinea-pig complement, that is, results in the complete or partial destruction of complement in a hemolytic system with partial or complete inhibition of hemolysis. This condition, however, should not be confused theoretically or practically with a positive Wassermann reaction. The intravenous injection of 0.6 gm. of arsphenamin or 0.9 gm. of neo-arsphenamin to a person of such weight that the drugs are diluted with 2,000 c.c. of blood and tissue juices would result in each 0.2 c.c. of serum containing 0.00006 or 0.00009 gm. of the drugs, provided the blood was drawn immediately after injection and if the proposition could be reduced to such simple terms, which is obviously not the case; these amounts added to normal serum in vitro have no demonstrable influence on the activity of complement or the Wassermann reaction.

While Dr. Strickler and his colleagues have exercised commendable care in efforts toward excluding syphilitics from their series of cases, yet the possibility exists that some cases of latent syphilis may have been included, particularly since the patients were selected from a public clinic. In order to exclude this factor, several months ago I conducted a similar set of experiments employing normal rabbits, under which conditions the question of syphilis could be definitely excluded and the influence of arsphenamin on the serum in relation to the Wassermann reaction studied under more ideal circumstances.

Due care was exercised in excluding animals yielding positive Wassermann reactions, as it is proved that normal rabbit serums sometimes yield positive Wassermann reactions, especially after the serums have been heated at 55 C. for thirty minutes. As shown by Dr. Pearce and myself, this quality of the serum of a rabbit remains constant for the animal; that is, if the serum of an animal reacts negatively it continues to do so over an indefinite period of time.

Preliminary Wassermann tests yielded negative reactions, each serum being tested unheated and by two methods: my routine method (the same as that employed by my assistants in testing the series of serums submitted by Dr. Strickler) and my new quantitative technic based on the results of a series of studies on the standardization of the Wassermann reaction conducted during the last five years. In the former test, each serum was used in amounts of from 0.1 to 0.2 c.c.; in the latter test, which is far more delicate, the serums were used in amounts ranging from 0.005 to 0.00001 c.c., with refrigerator incubation.

One series of animals received from six to ten intravenous injections of alkalized solutions of arsphenamin in dose of 0.01 gm. per kilogram of weight, equivalent to 0.6 gm. per 60 kg., or the weight of a young adult; a second series received from six to ten intravenous injections of solutions of neo-arsphenamin in dose of 0.02 gm. per kilogram of weight, equivalent to 1.2 gm. per 60 kg. A third series received from six to ten intravenous injections of mercuric chlorid in dose of 0.00033 gm. per kilogram of weight, equivalent to 0.0193 gm., or a little over 1 grain per 60 kg.

These injections were given at intervals of one week, blood being drawn for the Wassermann tests just before each injection, which was one week after the preceding dose of each drug. The conditions of the experiment were therefore almost identical with those surrounding the investigation of Strickler, Munson and Sidlick except that rabbits were employed and the Wassermann tests conducted under my immediate supervision and observation.

The results were entirely negative; the serum of no rabbit in any of the three series acquired the property of yielding positive Wassermann reactions with either technic.

Several years ago Miss Trist and myself found that single large doses of arsphenamin (0.07 gm. per kilogram of weight) had no influence on the Wassermann reaction with normal rabbit serums; that is, the serums of normal rabbits did not acquire the property of giving positive reactions, nor were the serums of rabbits yielding positive reactions so changed that negative reactions were induced. The present series of experiments have yielded exactly similar results. Of course, it is possible for arsphenamin and neo-arsphenamin to have a different influence on human tissues than on those of the normal adult rabbit, but I believe that these results are quite significant.

Despite the evidence here presented, the observations of Strickler and his colleagues are not to be lightly dismissed and should be held *sub judice;* the studies of Dr. Lucke and myself bearing on the histologic changes produced by arsphenamin, neo-arsphenamin and mercury in rabbits have shown that some tissue changes are induced, and it is possible that these may influence the physiochemical properties of the serum and result in producing such alterations in some serums as would result in a positive Wassermann reaction.

At present, I am unconvinced that arsphenamin produces such changes in nonsyphilitic individuals as would result in their serums yielding genuine positive Wassermann reactions; on the other hand, additional evidence is furnished for the necessity of further studies on the mechanism of the Wassermann reaction and additional safeguards against error in conducting the tests.

JOHN A. KOLMER, M.D., Philadelphia.

TREATMENT OF TRICHURIS INFESTATION

To the Editor:—In an editorial in THE JOURNAL (Aug. 21, 1920, p. 543) the statement is made that "there is no treatment of proved efficacy against the whipworm, *Trichuris,*" a statement also made in "The Practical Medicine Series 4:150, 1919. The same statement is made by many other authors. My purpose in this communication is to call the attention of American physicians to the valuable vermicidal action against this parasite of the latex of the plant known in Colombia under the name "*higuerón*" (*Ficus glabrata H. B. K.*, after Santiago Cortés, Flora de Colombia, p. 227). The doses vary naturally, according to age, being 50 c.c. for an adult, followed two hours afterward by a laxative, generally a saline. The treatment possesses definite value and has been used for a long while by Colombian physicians. As references, I may mention: *Repertorio de Medicina y Cirugía de Bogotá* 3:3, 99, 135, 1911, and *Gaceta Médica de Bogotá* 2:40, 1912. It has also been stated to possess some value for the treatment of other parasites (hookworm); but for these it is inferior to thymol, which, I may say by the way, is superior to chenopodium.

JORGE H. TASCON, M.D., Buga (Valle) Colombia, S. A.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, Jan. 11. Sec., Dr. Samuel W. Welch, Montgomery.

ARIZONA: Phoenix, Jan. 4-5. Sec., Dr. Ancil Martin, 207 Goodrich Bldg., Phoenix.

COLORADO: Denver, Jan. 4. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.

DISTRICT OF COLUMBIA: Washington, Jan. 11-13. Sec., Dr. Edgar P. Copeland, The Rochingham, Washington.

HAWAII: Honolulu, Jan. 10-13. Sec., Dr. J. E. Strade, 1041 Alakea St., Honolulu.

INDIANA: Indianapolis, Jan. 11. Sec., Dr. W. T. Gott, Crawfordsville.

KANSAS: Topeka, Feb. 8. Sec., Dr. Henry A. Dykes, Lebanon.

MINNESOTA: Minneapolis, Jan. 4-6. Sec., Dr. Thomas McDavitt, 539 Lowry Bldg., St. Paul.

MINNESOTA: National Board of Medical Examiners, St. Paul, Minneapolis and Rochester, Feb. 23-March 2. Sec., Dr. J. S. Rodman, 1310 Medical Arts Bldg., Philadelphia.

MISSOURI: St. Louis, Jan. 18-20. Sec., Dr. George H. Jones, Jefferson City.

NEW MEXICO: Santa Fe, Jan. 10-11. Sec., Dr. R. E. McBride, Las Cruces.

NEW YORK: New York City, Albany, Syracuse and Buffalo, Jan. 24-27. Asst., Professional Examinations, Mr. Herbert J. Hamilton, State Education Bldg., Albany.

NORTH DAKOTA: Grand Forks, Jan. 4. Sec., Dr. George M. Williamson, Grand Forks.

OKLAHOMA: Oklahoma City, Jan. 11-12. Sec., J. M. Byrum, Shawnee.

OREGON: Portland, Jan. 4-6. Sec., Dr. Urling C. Coe, 1208 Stevens Bldg., Portland.

PENNSYLVANIA: Philadelphia, Jan. 11-15. Sec., Dr. Thomas E. Finnegan, Harrisburg.

RHODE ISLAND: Providence, Jan. 6-7. Sec., Byron U. Richards, Providence.

SOUTH DAKOTA: Pierre, Jan. 18. Director, Division of Medical Licensure, Dr. H. R. Kenaston, Bonesteel.

UTAH: Salt Lake City, Jan. 3-4. Acting Sec., Dr. C. L. Olsen, Salt Lake City.

VERMONT: Burlington, Feb. 8-10. Sec., Dr. W. Scott Nay, Underhill.

WASHINGTON: Spokane, Jan. 4-6. Sec., Dr. William M. O'Shea, Spokane.

WEST VIRGINIA: Charleston, Jan. 13. Sec., R. T. Davis, Charleston.

WISCONSIN: Madison, Jan. 11-13. Sec., Dr. John M. Dodd, Ashland.

Maryland June Examination

Dr. J. McP. Scott, secretary, Maryland State Board of Medical Examiners, reports the written examination held at Baltimore, June 22-25, 1920. The examination covered 9 subjects and included 90 questions. An average of 75 per cent. was required to pass. Of the 95 candidates examined, 87 passed and 8 failed. Forty-three candidates were licensed by reciprocity. Four candidates were licensed by special examination. The following colleges were represented:

College	Year Grad.	Per Cent.
PASSED		
Howard University	(1918) 81, (1920) 79	
Johns Hopkins University	(1914) 82, (1917) 82, (1918) 80, 84, 86, 89, (1920) 77, 78, 79, 79, 79, 79, 80, 80, 81, 81, 82, 83, 83, 83, 83, 84, 85, 85, 85, 85, 85, 86, 86, 86, 86, 87, 89, 89, 89, 90, 91, 91, 91, 92, 92, 92	
University of Maryland	(1908) 75, (1916) 75, (1917) 80, 82, (1920) 76, 76, 78, 79, 80, 80, 80, 80, 80, 82, 82, 83, 83, 83, 83, 84, 85, 86, 86, 86, 87, 87, 87, 87, 88, 89, 90, 91, 93, 93, 96	79,
University and Bellevue Hospital Medical College	(1911)	88
Jefferson Medical College	(1920)	79
Meharry Medical College	(1920)	75
FAILED		
Baltimore University	(1899)	23
Johns Hopkins University	(1920)	67
University of Maryland	(1917) 72, (1920) 71,	72
Temple University	(1917)	69
Meharry Medical College	(1920)	63
SPECIAL EXAMINATION		
George Washington University	(1908)	*
Harvard University	(1893)	*
University of Michigan Homeo. Medical School	(1905)	*
McGill University Faculty of Medicine	(1900)	*

College	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
College of Medical Evangelists		(1916)	Dist. Colum.
Cooper Medical College		(1893)	California
Columbian University		(1898), (1900)	Dist. Colum.
Georgetown University School of Medicine		(1909)	Dist. Colum.
George Washington University		(1916), (1917, 2)	(1918) Dist. Colum.
Howard University		(1904), (1907),	(1919) Dist. Colum.
Atlanta Medical College		(1889), (1914)	Georgia
Chicago College of Medicine and Surgery		(1910)	Penna.
Hahnemann Medical College, Chicago		(1903)	Illinois
Northwestern University Medical School		(1911)	Illinois
Bennett Medical College		(1913)	Illinois
University of Louisville		(1905)	New Jersey
Baltimore Medical College		(1904)	Penna.
College of Physicians and Surgeons, Baltimore		(1910), (1911), (1915, 2)	West Virginia, (1914) Kentucky
Maryland Medical College, Baltimore		(1903)	Tennessee
University of Maryland		(1894), (1909)	Virginia
(1914) W. Virginia, (1917) District of Columbia			
Harvard University, Boston		(1914)	Penna.
University of the City of New York		(1886)	Penna.
Leonard Medical School		(1912)	Georgia
University of Pennsylvania, Department of Med. (1901) Pennsylvania		(1894)	Ohio
Western Pennsylvania Medical College		(1892)	Penna.
Meharry Medical College		(1902)	Kentucky, (1906) Georgia
University of Vermont College of Medicine		(1919)	Vermont
Medical College of Virginia		(1913)	W. Virginia
University of Virginia		(1898)	West Virginia, (1908) Dist. Colum.
Royal College of Surgeons, England		(1915)	Dist. Colum.

* No grade given.

California June and July Examination

Dr. C. B. Pinkham, secretary, California State Board of Medical Examiners, reports the written, oral and practical examination held at San Francisco, June 28 to July 1, 1920. The examination covered 9 subjects and included 90 questions. An average of 75 per cent. was required to pass. Of the 109 candidates who took the physician's and surgeon's examination, 94, including 1 osteopath, passed, and 15, including 5 osteopaths and 1 chiropractor, failed. Seventeen candidates received drugless practitioners' certificates. One hundred and fifty-six candidates, including 4 osteopaths and 1 undergraduate, were licensed by reciprocity. Eight candidates were licensed by endorsement of credentials. The following colleges were represented:

College	Year Grad.	Per Cent.
PASSED		
College of Medical Evangelists	(1920) 85, 85.6, 86.4, 88.8, 89.2, 89.3, 89.6, 89.6, 89.7, 90.3, 92.5.*	82.7,
College of Physicians and Surgeons, Los Angeles	(1920) 83.6, 85.7, 86.2, 87.6, 89.5 *	82.7,
College of Physicians and Surgeons, San Francisco	(1920) 80.3, 82.3, 83.2, 83.4, 83.5, 83.6, 84.5, 85, 86.7, 88.1, 89.6, 90, 92.3	76,
Leland Stanford Junior University School of Med.	(1920) 83.1, 84.6, 86.3, 86.8, 86.6, 87.5, 87.5, 88.3, 89.1, 90, 91.1, 91.5, 91.7, 93.1	82.5,
Oakland College of Medicine and Surgery	(1920) 86.2	87.1, 87.6
University of California Medical School	(1920) 83, 83.3, 83.8, 84.7, 86, 86.2, 87.2, 87.3, 89.4, 89.6, 89.9, 90.6, 90.9, 92.4, 94.4, 95.* *	76.7,
George Washington University	(1917)	87.8
Northwestern University	(1920)	90
Rush Medical College	(1917) 92.1, (1919)	88.3
University of Illinois	(1920)	87
State University of Iowa College of Medicine	(1919)	87.5
Harvard University	(1920)	87.1
University of Minnesota Medical School	(1920)	78.6
St. Louis University School of Medicine	(1920)	80.8, 85.5
Washington University Medical School	(1920)	91.5
Western Reserve University School of Medicine	(1919)	80.3
Jefferson Medical College	(1918) 77.1, (1919)	91.6
University of Pennsylvania	(1917)	85.8
University of Pittsburgh School of Medicine	(1919)	90.2
Vanderbilt University Medical Department	(1914)	86.4
University of Texas Department of Medicine	(1917)	83.1
University of Vermont	(1919)	83.5
Kyoto Prefecture Special Medical School	(1912)	*
Nippon Special Medical School, Tokyo	(1907)	*
FAILED		
College of Physicians and Surgeons, Los Angeles	(1920)	68.5, 71.7
College of Physicians and Surgeons, San Francisco (1920) 73.5	(1918)	62,
Oakland College of Medicine and Surgery	(1920)	72.2
Johns Hopkins University Medical School	(1917)	67.1
Aichie Prefecture Spec. Medical School Nagoya	(1907)	63.4
Tokyo Charity Hospital Special Medical School	(1914)	*
University of Glasgow	(1884)	62.2

College	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
University of Arkansas Medical Department		(1916)	Arkansas
California Medical College		(1905, 2)	Texas
Denver and Gross College of Medicine		(1904)	Washington
University of Colorado School of Medicine		(1917)	Colorado
Georgetown University		(1895)	S. Dakota
George Washington University		(1908)	W. Virginia
(1910) District of Columbia, (1916) Tennessee			
Atlanta College of Physicians and Surgeons		(1907)	Georgia
University of Georgia Medical Department		(1890)	Washington
Bennett College of Eclectic Medicine and Surgery (1905) Indiana		(1886)	S. Dakota
Chicago College of Med. and Surg.		(1908), (1913),	(1915) Illinois
Chicago Homeopathic Medical College		(1895)	New York
College of Physicians and Surgeons, Chicago		(1897)	Texas
(1903, 2) Illinois, (1904) Minnesota, (1907, 2) Illinois, (1908) Utah, (1900) South Dakota			
Hahnemann Med. Coll. of Chicago		(1891), (1902),	(1903) Illinois
(1912) Iowa			
Northwestern University		(1897), (1902),	(1912) Illinois
Rush Medical College		(1884) Kansas,	(1890) Minnesota
(1893), (1896) Illinois; (1900), (1901) Washington; (1904) Illinois; (1906) Utah; (1909) Illinois; (1910) Washington; (1911), (1913) Illinois; (1913) Washington; (1916) Illinois			
Drake University College of Med.		(1909)	Illinois, (1910) Iowa
Keokuk Medical College			(1908) Iowa
State University of Iowa Coll. of Homeo. Medicine			(1908) Iowa
State University of Iowa Coll. of Medicine (1915) Iowa			(1895) Iowa

Indiana Medical College	(1906)	Indiana
State College of Phys. and Surgs., Indianapolis	(1907)	Indiana
College of Physicians and Surgeons, Kansas City	(1898)	Illinois
University of Kansas School of Medicine	(1918)	Missouri
University of Louisville Medical Department	(1884) (1909) Arizona, (1916) Kentucky	Utah
Flint Medical College of New Orleans	(1906)	Louisiana
Tulane University	(1901) Oregon, (1912)	Louisiana
Baltimore Medical College	(1903) Washington, (1898)	Vermont
College of Physicians and Surgeons, Baltimore	(1895)	Texas
Johns Hopkins University	(1901) Connecticut, (1914)	Wisconsin
University of Maryland	(1909)	Maryland
Boston University School of Med.	(1903) Illinois, (1914)	Mass.
Harvard University	(1902) Arizona, (1911) (1916) Massachusetts, (1919) Massachusetts	Illinois
Detroit College of Med. and Surg.	(1900), (1910), (1913)	Michigan
University of Michigan Medical School	(1906) (1910), (1915), (1917) Michigan	S. Dakota
Hamline University	(1897) Oregon, (1903) (1907) North Dakota	N. Dakota
University of Minnesota Medical School	(1895), (1908) (1915) Oregon	Minnesota
Barnes Medical College	(1907)	Illinois
Ensworth Medical College	(1892) Kansas, (1908) (1914) Missouri	Wyoming
Homeopathic Medical College of Missouri	(1890)	Illinois
Missouri Medical College	(1895)	Illinois
National University of Arts and Science	(1915)	Missouri
St. Louis College of Physicians and Surgeons	(1910)	Missouri
St. Louis University School of Medicine	(1906), (1907) (1908) Illinois, (1918) Missouri	Missouri
University Medical College of Kansas City	(1909)	Kansas
Washington University Medical School	(1911), (1912)	Missouri
John A. Creighton Medical College	(1911), (1915), (1918)	Nebraska
Lincoln Medical College	(1906), (1910)	S. Dakota
University of Nebraska College of Medicine	(1898)	Nebraska
Bellevue Hospital Medical College	(1890)	Iowa
Columbia University	(1898) Connecticut; (1904), (1910)	New York
Long Island College Hospital	(1900), (1909), (1911)	New York
New York Homeo. Med. Coll. and Flower Hospital	(1909)	New York
New York University Medical College	(1881)	New York
Syracuse University College of Medicine	(1905)	New York
University at Buffalo Department of Medicine	(1893)	New York
Cleveland College of Physicians and Surgeons	(1910)	Ohio
Ohio Medical Univ.	(1897) Indiana, (1898) Ohio, (1903)	Oklahoma
Western Reserve University School of Medicine	(1902)	Illinois
Hahnemann Med. Coll. and Hosp. of Philadelphia	(1909)	Penna.
Jefferson Medical College	(1881) Illinois; (1907)	Utah
Medico-Chirurgical College of Pennsylvania	(1906) (1908), (1910), (1915) Pennsylvania	New Jersey
Temple University	(1910)	Penna.
University of Pennsylvania	(1899) Iowa; (1906)	Penna.
University of Pittsburgh School of Medicine	(1909) (1910) Iowa	Penna.
Western Pennsylvania Medical College	(1905)	Penna.
Meharry Medical College	(1916) Missouri; (1916)	Alabama
Vanderbilt University	(1899)	Tennessee
Marquette University School of Medicine	(1913)	Washington
Milwaukee Medical College	(1901)	Wisconsin
Wisconsin College of Phys. and Surgs., Milwaukee	(1901)	Wisconsin
University of Vermont College of Medicine	(1896) (1907) Vermont	Mass.
Queens University Faculty of Medicine	(1902)	N. Dakota
University of Toronto Faculty of Medicine	(1910)	Montana
University of Naples	(1907)	New York
Tokyo Charity Hospital Special Medical School	(1907)	Nevada
Royal College of Surgeons, England	(1901)	Missouri
National University, Athens	(1900)	Utah
Undergraduate		Vermont

College	ENDORSEMENT OF CREDENTIALS	Year Grad.	Endorsement with
Georgetown University		(1901)	U. S. Navy
Tulane University		(1916)	U. S. Army
Johns Hopkins University	(1908) U. S. Army.	(1907)	U. S. Navy
University of Michigan		(1899)	U. S. Army
St. Louis University School of Medicine		(1905)	U. S. Navy
Medico-Chirurgical College of Pennsylvania		(1906)	U. S. Army
University of Pennsylvania		(1907)	U. S. Navy

* Grade not given.

Kansas June Examination

Dr. Henry A. Dykes, secretary, Kansas State Board of Medical Examiners, reports the written examination held at Kansas City, June 15, 1920. The examination covered 10 subjects and included 100 questions. An average of 75 per cent. was required to pass. Twenty-six candidates were examined, all of whom passed. Fourteen candidates were licensed by reciprocity. The following colleges were represented:

College	PASSED	Year Grad.	Total No. Examined
Univ. of Kansas School of Medicine	(1917) 1, (1920) 22		23
University of Pennsylvania School of Medicine		(1920)	1
University of Pittsburgh School of Medicine		(1920)	1
University of Texas Department of Medicine		(1920)	1

College	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Loyola University		(1916)	Illinois
Northwesetrn University Medical School		(1918)	Missouri
University of Illinois		(1918)	Illinois
College of Physicians and Surgeons, Keokuk		(1887)	Wyoming
State University of Iowa College of Medicine		(1918)	Iowa
University of Kansas School of Medicine		(1906)	Missouri
Beaumont Hospital Medical College		(1902)	Illinois
St. Louis University School of Medicine		(1917)	Missouri
Washington University Medical School		(1909)	Missouri
University of Nebraska College of Medicine	(1918)	(1920)	Nebraska
Physio-Medical College, Cincinnati		(1914)	Ohio
Jefferson Medical College of Pennsylvania		(1894)	Missouri
University College of Medicine, Richmond		(1905)	W. Virginia

Book Notices

INGUINAL HERNIA: THE IMPERFECTLY DESCENDED TESTICLE AND VARICOCELE. By Philip Turner, M.S., F.R.C.S., Assistant Surgeon, Guy's Hospital. Cloth. Price, $3 net. Pp. 104, with 22 illustrations. Philadelphia: P. Blakiston's Son & Co., 1919.

The author presents in an interesting, readable manner the anatomy and pathology of the inguinal canal and scrotum in relation to inguinal hernia, maldescent of the testis, and varicocele. He then points out the objections to the ordinary surgical management employed for their cure, and describes in detail the technic that he has successfully used. The results are based largely on operations he performed while serving with the British during the war, his subjects being healthy young adults, who were carefully observed during convalescence, and many of whom were followed and examined several months after their return to duty. The author considers the congenital sac as the potential cause of most inguinal hernias, and its complete removal the most important step in the operative technic. In young persons and in early hernias in well developed adults he considers repair of the posterior wall of the inguinal canal not only unnecessary but an interference with the normal action of the internal oblique muscle. When the canal has been distorted and weakened by long continued pressure of a large sac or truss, the usual methods of repair are indicated. But in every case, the intercolumnar fibers of the aponeurosis at the external ring, unless found to be abnormal, should be preserved intact. The author's treatment of maldescent of the testis, the pathology of which is admirably discussed, is unique in that he plants the testis in the opposite side of the scrotum through an opening in the scrotal septum. In the repair of varicocele, after removal of the segment of varicosed veins, the low lying position of the testis is overcome, not by tying together the stumps of ligated veins, but by a transverse closure of the longitudinal incision in the fascial and muscular coverings of the cord. The end-results of the author's technic as reported appear highly favorable.

LEHRBUCH DER PERKUSSION UND AUSKULTATION. Mit Einschluss der Ergänzenden Untersuchungsverfahren der Inspektion, Palpation und der Instrumentellen Methoden. Von Dr. Ernst Edens, A. O. Professor an der Universität zu München Z. Zt. St. Blasien. Paper. Price, 64 marks. Pp. 498, with 249 illustrations. Berlin: Julius Springer, 1920.

The major portion of this work is taken up with an admirable exposition of the anatomic and physiologic conditions that underlie auscultation and percussion of the chest in health and disease. Thus, among other subjects, dulness on percussion as it pertains to the heart and lungs, the varieties of râles, the origin of the normal heart tones and how and why they may be altered are exhaustively considered. The physical examination of the blood vessels is also discussed in a satisfactory manner. The references that are made to the use of the roentgen ray, the polygraph and the electrocardiograph are too scanty to be of much value. There is a brief chapter on the examination of the abdominal organs. This is so incomplete that it might well have been omitted. The book is to be commended, therefore, for its excellent summary of the fundamental principles of auscultation and percussion as applied in diseases of the chest.

A TEXT-BOOK OF HUMAN PHYSIOLOGY, INCLUDING A SECTION ON PHYSIOLOGIC APPARATUS. By Albert P. Brubaker, A.M., M.D., LL.D., Professor of Physiology and Medical Jurisprudence in the Jefferson Medical College. Sixth Edition. Cloth. Price, $4.25 net. Pp. 795, with 356 illustrations. Philadelphia: P. Blakiston's Son & Co., 1919.

This textbook, prepared for the guidance of medical students and practitioners, may fill adequately a local want; but it certainly does not measure up to the standard of other well known texts in which less space is devoted to anatomic considerations, more space to the advances in biochemistry, and the subject matter of mechanical physiology itself presented in a more critical and less descriptive manner. America may justly be proud of its contributions to the science of nutrition. Reference is made in this book to the work of Folin and others on intermediary protein metabolism. On the other hand, no mention is made of the beautiful work of Mendel and Osborne on the specific value of certain amino-acids in

growth and nutrition. THE JOURNAL has done its utmost in calling the attention of the medical profession through its editorial columns to these matters as well as to the enormously important rôle of the accessory substances, or vitamins, referred to by some as fat-soluble A, water-soluble B, and water-soluble C. Even the educated layman speaks with some intelligence about deficiency diseases due to a faulty diet because of the absence of one or several of these substances. And yet this textbook absolutely ignores these matters; for the author must certainly be familiar with the facts and their practical importance. We expect a modern textbook to discuss diseases due to a deficiency of the diet not referable to its caloric value or its carbohydrate, fat or protein, salt or water content. We expect to find in it some discussion of antibodies, basal metabolism, the functional control of the capillaries, and a better discussion of the more striking advances in the field of internal secretion. There are no direct bibliographic references to the original literature.

EPIDEMIC ENCEPHALITIS (ENCEPHALITIS LETHARGICA). By Frederick Tilney, M.D., Ph.D., Professor of Neurology, Columbia University, and Hubert S. Howe, A.M., M.D., Instructor in Neurology, Columbia University. Cloth. Price, $3.50. Pp. 252, with 58 illustrations. New York: Paul B. Hoeber, 1920.

This brochure is divided into two parts. The first is devoted to the clinical description of the various types of the disease as manifested by twenty cases observed by Drs. Tilney and Riley. There is a somewhat condensed description of the cases grouped under the eight headings: lethargic, cataleptic, paralysis agitans, poliencephalitic, acute anterior poliomyletic, posterior poliomyelitic, epileptomaniacal and acute psychotic, and infantile types. There is a discussion of the symptoms, with chapters on prognosis and diagnosis, nature and treatment. There are a few illustrations. The second part deals with eleven cases of Howe's. The illustrations are more numerous, and the case reports are more complete. There are three necropsy reports. No novel conclusions are drawn from this material. The book may be considered as a valuable contribution to the accumulation of the data on this disease.

DR. G. HERSCHELL'S TEXTBOOK OF INDIGESTION. Revised and Rewritten by Adolphe Abrahams, O.B.E., M.D., M.R.C.P., Assistant Physician to Westminster Hospital. Fourth edition. Cloth. Price, $3.75. Pp. 228. New York: Longmans, Green and Co., 1920.

This is a complete revision of the original textbook with the exception of the appendix on the preparation of foods for dyspeptics, which remains substantially unaltered. The book contains nothing that is new; it is not based on careful scientific investigation; furthermore, it contains numerous statements not in accord with the accepted facts. While many references are made to English and a few to German literature, there are virtually none to American studies and reports. The work is of no particular value to the medical profession.

THE DEVELOPMENT OF THE HUMAN BODY. A Manual of Human Embryology. By J. Playfair McMurrich, A.M., Ph.D., LL.D., Professor of Anatomy in the University of Toronto. Sixth edition. Cloth. Price, $3.25. Pp. 501, with 290 illustrations. Philadelphia: P. Blakiston's Son & Co., 1920.

This manual of embryology, now in its sixth edition, has become recognized as a standard textbook and is used in many of our best medical schools. The present edition is brought up to date and contains the results of recent contributions on the subject. Embryology is here considered particularly with reference to the requirements of medical training. The manual is complete and at the same time compact.

LECTURES ON SURGERY TO NURSES. By Alan H. Todd, B.Sc., M.S., F.R.C.S. Cloth. Price, $2.75. Pp. 270, with 17 illustrations. New York: Longmans, Green & Co., 1920.

In the belief that the nurse should have sufficient knowledge of medicine to know the reason for doing things, and thus to be an intelligent cooperator with the physician, Dr. Todd publishes these lectures, originally delivered at Guy's Hospital, London. They read as if they might have been taken down by the stenographic method, and do not seem to be especially prepared for publication. The whole field of surgery is covered in very brief form.

Medicolegal

Liability in Operating Without Proper Consent

(Moss et al. v. Rishworth (Texas), 222 S. W. R. 225)

The Commission of Appeals of Texas, Section A, says that the authorities are unanimous in holding that a surgeon is liable for operating on a patent, unless he obtains the consent of the patient, if competent to give such consent, or, if not, of some one who, under the circumstances, would be legally authorized to give the requisite consent. If a person should be injured to the extent that he is unconscious, and his injuries are of such nature as to require prompt surgical attention, a physician called to attend would be justified in applying such treatment as might reasonably be necessary for the preservation of his life or limb, and consent on the part of the injured person would be implied on the ground of an existing emergency.

In this case, a child 11 years old, who was visiting an adult sister 60 miles from where her parents lived, was taken by the sister to defendant Moss to be examined to ascertain whether an operation was needed for the removal of adenoids, explaining that the child had difficulty in breathing and was subject to attacks of rheumatism. An examination by Dr. Moss disclosed badly diseased tonsils and the appearance of adenoids, and he stated that a real necessity existed for an operation to remove the diseased tonsils and adenoids. A date for the operation was agreed on, and the child returned with that sister and another one, who, like the first one, had had training as a nurse. After an examination of the child's heart, an anesthetic was administered, and the tonsils and adenoids were removed; but, before coming from under the influence of the anesthetic, the child died. The child's father, plaintiff Rishworth, therefore brought this acton to recover damages. By amended pleading, he abandoned all allegations of negligence and unskilfulness, and relied for recovery solely on the ground that the operation was without his consent. The trial court instructed the jury that if the defendants, without the consent of the parents, operated on the child, using an anesthetic, and she died as the result of the operation or the effect of the chloroform or both, to find for the plaintiff, without regard to any question of negligence or unskilfulness; but the jury returned a verdict for the defendants, and a judgment was rendered in their favor. On an appeal, that judgment was reversed by the court of civil appeals, which reversal meets with the approval of the commission of appeals, which says that the judgment of the court of civil appeals should be affirmed.

The evidence, the commission says, showed that there was an absolute necessity for a prompt operation, but not emergent in the sense that death would likely result immediately on failure to perform it. In fact, it was not contended that any real danger would have resulted to the child had time been taken to consult the parent with reference to the operation. Therefore the operation was not justified on the ground that an emergency existed. The physicians, acting in good faith, in assuming that the sisters had authority to give consent, undertook to perform the operation, and, although the operation was skilfully performed and without negligence, death ensued, either as the result of the operation or of administering the anesthetic, or both. The sisters were but the temporary custodians of the child, and as such temporary custodians had no authority to give consent to perform the operation in the absence of an emergency. The parent was the only one who could legally give consent to perform it, and, if not given, the physicians' act in performing it was a legal wrong. If performed without the consent of the parent, it would amount to a technical assault for which the child could have recovered damages, and it follows that, under the Texas statute, the cause of action would survive to the plaintiff, not dependent on the extent of the injuries to the minor child. It was insisted that the paramount interest of the child alone must be considered in determining whether such an operation should be performed, and that if her health demanded an operation and it was skilfully performed, no

cause of action arose, even though it resulted disastrously. But the law wisely reposes in the parent the care and custody of the minor child, and neither a physician nor those in temporary custody of the child, will be permitted, in a case of this character, to determine those matters touching its welfare.

Immunity in Charging Insanity

(Reade v. Halpin et al. (N. Y.), 182 N. Y. Supp. 45)

The Supreme Court of New York, Special Term, Albany County, in granting a motion for a judgment in favor of the defendants, who were sued far malicious prosecution because of certain lunacy proceedings against this plaintiff, says that public policy and the dictates of humanity require, for the protection of those of unsound mind and of society in general, that such persons be cared for. On the other hand, the liberty of a citizen and his good name must be jealously safeguarded. A charge of insanity does hold a person up to pity, and has a tendency to cause him or her to be shunned or avoided. Such a charge may be fraught with most mischievous and oppressive consequences. The law therefore permits a certain limited number of persons, standing in intimate relationship to the alleged insane person or certain public officers, to petition in insanity proceedings. Accompanying this petition there must be a certificate by two physicians specially qualified to make it. Where the physicians and the petitioner enter into a conspiracy with each other, or with others, to institute such proceedings maliciously and without probable cause, there should be a right of action for the damage suffered. Otherwise there would be little protection from the unscrupulous. When, however, two qualified medical examiners, independently and not in pursuance of a scheme and conspiracy on their part with others to accomplish an improper purpose, make a certificate in lunacy, it ought to furnish reasonable and probable cause to those who set on foot the proceeding under the insanity law, irrespective of their motives. The wise public purpose to be served in the protection of the public from those who by their apparent irrational acts have given rise to the necessity of an examination into their sanity should not be curtailed by subjecting the person privileged under the statute to initiate the proceeding to an action for malicious prosecution, when the proceeding has been terminated by a judicial finding of sanity, in the absence of proof of a conspiracy on the part of such actor with others maliciously and without probable cause to vex and harass and injure the person charged with insanity, or in the absence of any improper interference with the liberty of the individual during the course of the proceeding. In the case of such a conspiracy, or if the liberty of the person is improperly interfered with during, or as a result of, the proceeding, a different question is presented. In that event an action for false imprisonment or for malicious prosecution would arise.

Not Liable for Shortening of Leg One Inch

(Ayala v. King-Ryder Lumber Co. (La.), 83 So. R. 799)

The Supreme Court of Louisiana, in affirming a judgment in favor of the defendant, says that the plaintiff, a Mexican, who had his right leg broken between the knee and the hip while he was in the defendant's employ, sought to recover damages from the defendant for the alleged negligence and malpractice of the physician employed by the latter, which resulted in the shortening of the leg 2½ inches. The plaintiff described the treatment by the physician as first sticking a needle into his thigh, and then tying a board to the outside of his leg with some string and bandages. He said no weights were used. His testimony was supported by that of the nurse and four other witnesses, all of whom testified in Spanish with the aid of an interpreter. They all said that there was but one board used, and that was tied on the outside of the leg. Five physicians, who had heard the testimony of the plaintiff and the other witnesses, gave it as their opinion, as experts, that, according to the testimony which they had heard, the treatment accorded the plaintiff was unusual and inefficient. They testified further that a complete anesthetic, such as chloroform or ether, should have been used; that the injection of one-half grain of morphin and one-hundredth grain of scopolamin (hyoscin) administered was insufficient for all the purposes. If the testimony of the plaintiff and his five witnesses could be accepted as the truth, the opinion of these physicians would be accepted by the court as final. But the physician who attended the plaintiff denied positively what the witnesses had sworn to in connection with his treatment of the case. He testified that he had used the Linton splint, consisting of three boards, a model of which was with the record in the case, and that the Linton splint had been in general use for a long time for such fractures. His testimony was corroborated by the carpenter in the employ of the defendant, on whom he called at the time of the accident to make for him the Linton splint. The carpenter testified that the physician drew the plan of the apparatus; that he executed the work in exactly the way indicated by the physician, in his presence, and that it was finished within half an hour; and that he assisted the physician in adjusting the splint to the plaintiff's leg. The evidence of the physician and of the carpenter was direct, conclusive and convincing. The plaintiff's witnesses were unskilled Mexican laborers, who perhaps did not pay sufficient attention to the apparatus on the plaintiff's leg to know whether it consisted of one or of three boards, and they were testifying with the aid of an interpreter about a scientific subject and the manner in which it was being operated. Then, three physicians called as witnesses by the defendant testified, in support of the attending physician, that a complete anesthetic was not always necessary in treating a broken femur; that it depended largely on the condition of the patient, and that the physician in attendance was the best judge of whether relaxation of the muscles had taken place or not. They were of the opinion that the administration of morphin and scopolamin, as explained by the attending physician, was sufficient in some cases. They also testified that the use of the Linton splint was general throughout the hospitals in connection with a broken femur, and that it was used without weights. Moreover, the plaintiff's leg was measured, and, instead of being 2½ inches shorter than the other leg, it was found to be practically 1 inch shorter, while it would further appear from the evidence that with the most skilful treatment the shortening of an inch, or an inch and a half, might result. The court cannot, therefore, hold that the shortening of the plaintiff's broken leg was due to the fault, neglect or lack of skill of the physician in the employ of the defendant company. The trial judge was of the opinion that the plaintiff had failed to make out his case, and its judgment, rendered for the defendant, is affirmed.

Evidential Use of Memoranda Made by a Physician

(Williits v. Chicago, B. & Q. R. Co. (Mo.), 221 S. W. R. 65)

The Supreme Court of Missouri, Division No. 1, says that a physician was called as a witness for the defendant in this personal injury case. He had treated the plaintiff on the night on which she was injured and for the ten days that she was in a hospital. During that time he made two written memoranda as to the condition of the plaintiff and the treatment. He noted down the injuries found on her in the first one, and in the other he noted the condition of the wounds when she left the hospital, as well as the troubles of which she then complained. He was permitted to use these memoranda while testifying, and after being so used the defendant offered them in evidence, but they were excluded. Their exclusion was alleged to be error, but the court does not think that it was. The physician had testified as to all matters covered by his written memoranda. He had used them to refresh his recollection to the end that he might testify fully. When so used they had served their whole and only purpose in the course of the trial, so far as the defendant was concerned, whose witness the physician was. They could not be used as independent evidence of the facts recited therein. There was nothing to show these instruments to have been kept, as books are kept, in the regular course of business. They were both used to refresh the recollection of the witness, who, having his recollection refreshed, testified fully. There was therefore no error in the ruling excluding them from admission in evidence.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Diseases of Children, Chicago

December, 1920, 20, No. 6

*Pathology of Nutrition in Infancy. W. McK. Marriott, St. Louis.—p. 461.
*Studies on Heart in Nutritional Disturbances in Infancy. H. McCulloch, St. Louis.—p. 486.
*Infantile Spinal Progressive Muscular Atrophy (Werdnig-Hoffmann); Report of Case with Necropsy Findings. E. J. Huenekens and E. T. Bell, Minneapolis.—p. 496.
Congenital Atresia of Esophagus; with Report of Case. H. L. K. Shaw, Albany, N. Y.—p. 507.
Capacity of Stomach in First Ten Days of Postnatal Life. R. E. Scammon and L. O. Doyle, Minneapolis.—p. 516.
Studies in Spasmophilia. II. Electrical Reactions of Older Children. L. von Meyesenbug, Minneapolis.—p. 539.
*Empyema in Infants and Young Children. R. C. Spence, New York. p. 545.
*Urine Sugar in Infants. R. M. Greenthal, New York.—p. 556.

Nutritional Disturbances in Children.—Two types of nutritional disturbances are considered by Marriott, one an acute toxic-like condition usually following severe diarrhea; the other, a chronic state of failing nutrition commonly known as "marasmus." The prominent symptoms of each condition are mentioned and the cause of these symptoms is discussed.

Heart in Nutritional Disturbances in Infancy.—Electrocardiograms were made by McCulloch from a group of sixteen athreptic infants, and in the case of two of these infants, alterations of cardiac mechanism were observed. The alterations consisted of a delay in auriculoventricular conduction, and changes in the form of the Q R S complex. McCulloch suggests that these disturbances are the result of alterations in the blood and body tissues in these infants suffering from nutritional disorders. It is probable that the changes which have taken place in the blood result in a deficient supply of oxygen to the heart, with incomplete or delayed removal of metabolic products (acid metabolites) from the cardiac tissue. When improvement takes place in these athreptic infants the alterations in cardiac mechanism disappear. Measures adopted to relieve the nutritional disturbances seem to be the rational treatment for the cardiac condition as well. McCulloch has not observed any phenomena indicating heart failure in these infants.

Infantile Spinal Progressive Muscular Atrophy.—From a review of the literature and of their own case, Huenekens and Bell believe the conclusion seems justified that amyotonia congenita (Oppenheim) and infantile spinal progressive muscular atrophy (Werdnig-Hoffmann) are extreme types of the same disease; that they are probably both related to the group of myopathies represented by Erb's juvenile form of muscular dystrophy and the hereditary form of Leyden and Moebius.

Empyema in Infants.—Approximately 11 per cent. of all pneumonia patients admitted to the Babies' Hospital during the last seven years either had empyema at the time of admission or developed it during the stay in the hospital. Empyema was the sequel of pneumonia in every case. Pneumococcus in pure culture was present in the pus from the pleural cavity in 70 per cent. of these cases; the mortality for this type of infection is the lowest in the series. Spence states that the degree of leukocytosis is no guide to prognosis or to diagnosis. Siphon drainage has given better results in the treatment of empyema in infancy than any other method of treatment employed.

Sugar in Urine in Infants.—Greenthal states that the urine of all normal infants contains a determinable amount of reducing sugar. The amount of sugar excreted is not dependent on the volume of urine but is directly proportional to the amount of sugar ingested. As the amount of sugar in the diet is increased, the total urine sugar increases. This increase is chiefly in the fermentable portion and as a result the percentage of nonfermentable sugar becomes less. Sugar excretion in infants, both fermentable and nonfermentable, is fairly constant when the intake of sugar is constant.

American Review of Tuberculosis, Baltimore

November, 1920, 4, No. 9

*First Infection with Tuberculosis by Way of Lungs. E. L. Opie and H. Anderson, St. Louis.—p. 629.
*First Infection with Tuberculosis by Way of Intestinal Tract. E. L. Opie, St. Louis.—p. 641.
Case of Artificial Pneumothorax Complicated by Hydropneumothorax and Pleurisy with Effusion in Untreated Side. M. Fishberg, New York.—p. 649.
Roentgenologic Study of Influenza, with Recovery in an Advanced Case of Pulmonary Tuberculosis. L. T. Black and M. Moore, Denver.—p. 654.
*Masked Juvenile Tuberculosis. J. V. Cooke and T. C. Hempelmann, St. Louis.
Comparison of Gross Tuberculous Lesions in Whites and Negroes. J. L. Rogers, Cincinnati.—p. 669.
Tuberculosis Among Negroes. H. G. Carter, Burkeville, Va.—p. 676.
*Experimental Lesions of Lungs Produced by Inhalation of Fluids from Nose and Throat. W. V. Mullin and C. T. Ryder, Colorado Springs. —p. 683.
Relative Influence of Constitutional Factor in Etiology of Tuberculosis. R. Pearl, Baltimore.—p. 688.
Environmental Factors in Tuberculosis. A. K. Krause, Baltimore.—p. 713.

First Infection with Tuberculosis by Way of Lungs.—Study of the lesions of first infection with tuberculosis is urged by Opie and Andersen as being essential to an understanding of the mode of tuberculous infection and the conditions under which it occurs. With few exceptions roentgenograms of the lung of an adult demonstrate the presence of conspicuous calcified nodules in the lung and in adjacent lymph nodes, whereas in approximately half of all adults the healed pulmonary nodules, which are usually multiple, are from 0.5 to 1 cm. in diameter, and the more numerous nodules of the lymph nodes are from 1 to 2 cm. across. It is probable that these lesions were considerably larger and more numerous in their active stage, for tuberculous lesions tend to resolve when recovery occurs and persist as calcified masses only when caseation has been present. In more than one in every ten individuals the calcified lesions present in the lung at necropsy show that the individual has suffered with widely disseminated tuberculosis of the lung and massive tuberculosis of the adjacent lymph nodes. Evidence of extension of the tuberculous infection to distant organs is not uncommon and healed tubercles in the liver and spleen, usually in both, have been found by the authors in ten of fourteen instances of extensive healed tuberculosis of the lungs.

In one instance, in association with healed tuberculosis of the lungs and adjacent lymph nodes, more advanced than in any other instances and with healed tubercles of the liver and spleen, similar calcified nodules have been found in the pia mater. Tuberculous meningitis has been followed by recovery, with calcification of those meningeal tubercles which have undergone caseation. The distinction between latent and clinical tuberculosis, which is not infrequently made, has no other basis than the limitations of diagnostic methods and the tendency of tuberculosis to proceed to recovery.

First Infection with Tuberculosis by Way of Intestinal Tract.—Observations are recorded by Opie in order to explain the significance of tuberculous infection which occurs in childhood and at times in adult life and is recognizable subsequently as encapsulated and calcified foci of healed or healing tuberculosis. In a series of ninety-three necropsies made in 1917 on children and fifty necropsies made on adults no instance of healed mesenteric tuberculosis was found. Caseous or calcified mesenteric nodules were found in eighteen instances among sixty-six young male adults whose age with few exceptions varied from 20 to 30 years. Among fifteen necropsies the proportion of mesenteric tuberculosis was approximately the same. In a number of instances roentgenograms were made from both the mesentery and the lungs; and they serve to show with considerable accuracy the size and position of the calcified lesions which were present. In three instances the tuberculous lesion was still obviously caseous though it was encapsulated and doubtless localized. Calcification was so advanced that it had given the caseous material a mortar-like consistency. In thirteen instances the mesenteric lymph nodes contained completely healed firmly calcified tuberculous lesions. In a series of necropsies, evidence of first infection with tuberculosis was found in the lungs of every adult examined. Apical tuberculosis, which usually pursues a chronic course and in most persons under-

goes complete healing, has been found in the lungs of 22 per cent. of adults above the age of 18. In two of the eighteen instances of partially or completely calcified tuberculosis of the mesenteric lymph nodes described (and perhaps in a third), there has been apical tuberculosis of the lungs, which, unlike the primary focal lesions of the lung, is unaccompanied by evidence of tuberculosis of the adjacent lymph nodes at the hilum of the lung. When healed lesions are present in the mesentery focal tuberculosis of the lungs is seldom found. First infection with tuberculosis may occur by way of the lungs or by way of gastrointestinal tract; and the occurrence of one lesion tends to prevent the other.

Masked Juvenile Tuberculosis.—Cooke and Hempelmann state that masked juvenile tuberculosis presents a sufficiently distinctive clinical type to deserve a prominent place in the category of tuberculous affections in childhood. The characteristic clinical picture consists of: a history of frequent coughs and cold, with or without known exposure to tuberculosis, attacks of unexplained fever, often with afternoon elevations, anorexia, loss of weight and asthemia. On physical examination, there is found more or less malnutrition, occasionally anemia, and chest signs referable to enlarged tracheobronchial nodes. In certain instances there may be, in addition, phlyctenular disease or skin tuberculides. The von Pirquet or intracutaneous tuberculin tests are positive, and in those over four years of age, three-fourths of the children give a positive complement fixation test for tuberculosis. The chest findings may be verified by the use of the roentgen ray which not infrequently reveals unsuspected lesions of varying size and age in the lung parenchyma as well. The diagnosis must rest on a review of all the findings; and there the authors emphasize the value of the complement fixation test in calling attention to this class of cases.

Experimental Lesions of Lungs Produced by Inhalation.—By allowing rabbits to inhale suspensions of carbon or of tubercle bacilli from their upper air passages, Mullin and Ryder found that pigmentations or tuberculous lesions are produced which correspond very closely in distribution to the lesions of pulmonary tuberculosis in man.

Annals of Medicine, Hagerstown, Md.

July, 1920, **1**, No. 2

*Epidemic Encephalitis: Study of Cases with Necropsies. W. Boyd, Winnipeg, Canada.—p. 195.
*Early Diagnosis and Treatment of Choledochitis, Cholecystitis and Cholelithiasis. B. B. V. Lyon, Philadelphia.—p. 222.
Syphilis of Colon and Lower Bowel; Report of Three Cases. C. F. Karshner, Chicago.—p. 237.
Edema of Heart Muscle as a Cause of Cardiac Enlargement. A. Frick, Chicago.—p. 249.
*Acute Infectious Aortitis: Report of Cases. G. E. Brown, Miles City, Mont.—p. 254.
Infection of Digestive Tract; Late Radiographic Appearance of Digestive Tract in Chronic Enterocolitis. C. G. Stockton and C. F. Dewitz, Buffalo, N. Y.—p. 266.
*Value of Esophagoscopy in Diagnosis of Diseases of Esophagus. E. B. Freeman, Baltimore.
Etiologic Factors in Pulmonary Tuberculosis. R. S. Berghoff, Chicago.—p. 276.
Epigastric Hernia with Symptoms of Pyloric Obstruction. A. McGlannan, Baltimore.—p. 281.

Epidemic Encephalitis.—A study of seventy-five cases with sixteen necropsies was made by Boyd. The pathology may be summarized as interstitial inflammation of the central nervous system with secondary parenchymatous degeneration. In a number of cases of cranial nerve disturbance the corresponding nerve fibers were pressed on by greatly dilated vessels, the nuclei being comparatively normal. In seven cases peculiar hyaline bodies apparently the result of degeneration, were found in the central nervous system. Widespread hemorrhages were present in the serous membrances in three cases, pointing to a general septicemic condition. Vascular and degenerative changes were present in the kidneys in many of the cases.

Duodenal Medication in Disease of Bile Passages.—Direct observation and the local use of magnesium sulphate solutions in the duodenum of human beings are the subjects discussed by Lyon. He says that simple catarrhal jaundice may be treated very satisfactorily by this method. Choledochitis and cholangeitis may be treated successfully in favorable cases, especially where they have not been preceded by surgery. In the early cases of cholecystitis, as those complicating typhoid fever (potential typhoid carriers) and the "masked" focal infections of the gallbladder, the results are good. Empyema of the gallbladder has been treated successfully during its acute phases in patients who presented severe cardiorenal contraindications for surgery. Cholelithiasis remains entirely beyond the scope of this method, although stones have been made to pass through the common duct. The one field where this method is strongly recommended by Lyon is in the treatment of "biliary stasis," or faulty retention of gallbladder bile. It is also very important to search back for primary foci of matched bacteriology in the teeth, tonsils, sinuses, bronchial tract, stomach or duodenum and remove them. Many of these cases of biliary stasis are associated with various forms of migraine.

Acute Infectious Aortitis.—Retrosternal pain or distress, varying in degree from a mild stenocardia to a complete angina pectoris, is said by Brown to be an important symptom of acute aortic dysfunction. Minor changes in the aorta, as shown by roentgen-ray proof of its lengthening and elevation, may be the earliest demonstrable sign. The prognosis is not grave in the young. It depends on several associated factors; the type of infection, involvement of aortic valves, blocking of coronary arteries, and the degree of myocardial damage.

Value of Esophagoscopy.—Freeman urges esophagoscopy as a routine examination in all cases with symptoms referred to the region of the esophagus. By so doing, it will be possible in many cases to make an early diagnosis in diseases of the esophagus which, at present are not diagnosed until the disease is far advanced. Freeman warns against esophagoscopy in compression stenosis.

Boston Medical and Surgical Journal

Dec. 2, 1920, **183**, No. 23

*Leukocytic Reaction in Paratyphoid Dysentery and Following Vaccine Inoculations. G. Tryon, Boston.—p. 643.
Combined Operative and Radium Treatment of Malignant Disease of Nasal Accessory Sinuses. H. A. Barnes, Boston.—p. 648.

Leukocytic Reaction in Paratyphoid Dysentery.—The basis of Tryon's report are twelve cases of dysentery which appeared as an epidemic in 1915 in the Boston State Hospital. The organism which caused the disease belonged to the paratyphoid enteritidis group, but could not be identified with any of the well known members. Clinically, the disease appeared in three forms: a dysenteric-pneumonic, a dysenteric and a diarrheal. The duration of the disease was from five days to three weeks. The majority of the cases occurred among old and feeble women patients. The blood picture varied somewhat in different patients and in the same patient during the course of the disease. The total leukocyte counts were between 5,100 and 13,300. The differential count was not quite so variable as the total count, in that it remained more constant to the form of the disease. The percentage of polymorphonuclears was relatively higher, and that of the lymphocytes lower in the pneumonic than in the pure dysenteric form. In the dysenteric cases uncomplicated with pneumonia, the lymphocytes persisted rather high during the first two weeks, between 27 and 40 per cent.; in two recovered pneumonic cases, the lymphocytes showed a high percentage in the third week during convalescence, 37 and 43 per cent., respectively. A count made in one case of an acute arthritis following a short severe attack of dysentery resembled the pneumonic cases. Eosinophils were found in any case during the first week; in the second week they reappeared in from 5 to 2 per cent. Transitionals gave a higher percentage in the first than in the second week. In all cases blood platelets were much increased throughout the disease and in early convalescence. There was no evidence of an anemia judging from the hemoglobin percentage and the character of the red blood cells.

New York Medical Journal

Dec. 4, 1920, **112**, No. 23

*Parathyroid and Convulsive States. S. E. Jelliffe, New York.—p. 877.
More Adequate Provision for Epileptics. W. T. Shanahan, Sonyea.—p. 879.

*Comparative Study of Phenomena of Epilepsy. C. A. Marsh, New Castle, Ind.—p. 885.
*Mentality in Epilepsy. W. H. Kidder, Oswego, N. Y.—p. 889.
*Epilepsy Treated with Luminal. H. M. Watkins, Palmer, Mass.—p. 891.
Practical Experience in Training Treatment of Epileptics. T. E. Uniker, Stamford, Conn.—p. 892.
*Injections of Cerebrospinal Fluid in Cerebrospinal Fever. N. A. Cooper, Bombay, India.—p. 896.
Venesection: A Lost Art. D. W. Kramer, Philadelphia.—p. 898.
Relationship Between Diseased Tonsils and Pulmonary Tuberculosis. Wichita Falls, Tex.—p. 902.

Parathyroid in Epilepsy.—Jelliffe suggests the use of parathyroid in the treatment of epilepsy. Just to feed parathyroid to every epileptic and expect him to get well is silly he says behind the type of cases of possible action there should be present the specific features of the "hair trigger" synaptic activity. Careful study of the patient for all of the tetany reactions is needed. Interestingly enough, it has seemed that parathyroid given by rectum in its crude state is its most effective form. Given in other ways, by the gastro-intestinal canal, it undergoes destructive digestive changes; even hypodermic use seems to alter its composition, but taken by way of the rectum it would appear that no such deterioration takes place, and some very surprising and striking results have been obtained, not in the cure of an epileptic specially, but in the help of this one particular factor which Jelliffe emphasizes.

Nature of Epilepsy.—Epilepsy is considered by Marsh as an abnormal muscular expression of strong mental states. It is a particular type of reaction which occurs when purposeful efforts of mind and body come to defeat. It is seen in an individual who, possessing a poverty of interests in his environment, cannot, as the normal man does, escape strong emotional feeling by entertaining conflicting thoughts which weaken strong mental states.

Mentality in Epilepsy.—Kidder predicts that the time will be when the place of mental therapy in the treatment of epileptics will be firmly established.

Luminal in Epilepsy.—Watkins states that cures are not to be expected from the use of luminal in epilepsy. It is at best a palliative remedy. It is not virtually a specific. It reduces the total number of convulsions in all classes 66 per cent., although a small proportion of patients have an increased number of convulsions during its use. It has practically no effect on some patients, and about 10 per cent. show untoward symptoms from its use. It has all the bad effects of bromids with the exception of the rash. The drug must be used over a long period of time and continually, as once its administration is discontinued the epileptic habit returns with increased severity.

Injections of Cerebrospinal Fluid in Cerebrospinal Fever.—Cooper reports the case of a boy, aged 14, suffering from a severe form of cerebrospinal fever, who recovered completely from the malady, as well as all its concomitant adverse symptoms, nervous, sensory and muscular, under the injections of his own cerebrospinal fluid. The boy was admitted to the hospital April 7. All treatment failed to give relief. A lumbar puncture was made May 12 and 10 c.c. of fluid was withdrawn. It was sterile. Of this fluid 0.75 c.c. was injected subcutaneously, and it was repeated every day till the seventeenth. Gradually, the temperature fell and meningeal symptoms abated with every injection until May 18, when the temperature dropped to 97 F. The boy recovered slowly and left the hospital July 26 in perfect health and without the slightest defect.

Surgery, Gynecology and Obstetrics, Chicago

December, 1920, 31, No. 6

John B. Murphy—Surgeon. B. Moynihan.—p. 549.
Immobilization of Proximal Fragment in Fracture of Jaw Above Angle. W. T. Coughlin, St. Louis.—p. 574.
Management of Cervical Stump and Round and Broad Ligaments When Performing Supravaginal Hysterectomy. D. Bissell, New York.—p. 578.
Tumors of Breast. M. F. Porter, Ft. Wayne, Ind.—p. 584.
*Two Unusual Nerve Lesions. A. Gibson, Winnipeg, Manitoba.—p. 588.
*Blastomycosis. J. T. Moore, Houston, Tex.—p. 590.
*Subphrenic Abscess; Report of Case with Cure. A. Ullman and C. S. Levy, Baltimore.—p. 594.
Analgesia and Anesthesia in Labor. E. P. Davis, Philadelphia.—p. 601.
Treatment of Abortion. D. S. Hillis, Chicago.—p. 605.
Pregnancy Complicated by Influenza. S. A. Durr, Chicago.—p. 610.
Parasecular or Sliding Hernia. C. H. Criley, Los Angeles, Calif.—p. 611.
Two Hundred Fifty Operations on Gallbladder and Ducts. E. R. McGuire, Buffalo.—p. 617.
*Retroperitoneal Sarcoma. H. H. Trout and G. E. Meekins, Roanoke, Va.—p. 622.
Instrument for Application of Radium to Tumors of Bladder. W. H. Woolston, Chicago.—p. 627.
*Finger and Toe Nail Extension. J. E. M. Thomson, Lincoln, Neb.—p. 629.
*Use of Tendon of Psoas Parvus and Fascial Transplants in Treatment of Prolapse of Pelvic Viscera. G. C. Bryan, Walla Walla, Wash.—p. 630.

Unusual Traumatic Nerve Lesions.—In one of the cases cited by Gibson a piece of shell entered the right cheek and was removed by the stretcher bearer. The wound suppurated for a few days. No facial paralysis or even paresis resulted, and the wound, being satisfactorily healed, was ignored. Later the patient complained of twitching of the muscles of the right side of the face, with a tendency to lacrimation in the right eye when exposed to cold, to wind, or to bright sunshine. In addition to this, the skin on the right side of the face under the right lower eyelid, and at the root of the nose, was somewhat sensitive. He complained of a tickling sensation, this being pronounced even with a slight touch. By pressing his tongue against the buccal aspect of the upper lip and the right upper cheek he produced a tickling sensation in the face. Examination revealed a hole of some size filled in partly by scar tissue. This scar tissue involved branches of two sensory nerves: (1) the twigs from the infra-orbital branch of the maxillary division of the trigeminal, (2) the buccinator branch of the mandibular division of the same cranial nerve. The irritation of this scar has produced heightened sensibility of other sensory branches supplying the conjunctiva, and this reflexly induced increased secretion of the right lacrimal gland along with motor irritability of the facial muscles which are closely associated with the trigeminal sensory distribution. The second patient complained of weakness of the left hand, been present for six or seven months and gradually increasing. He had had no accident, and no injury to the back, left shoulder region, or left upper limb. His occupation was that of a butcher. The electrical reactions of the muscles of the hand were normal both to faradism and galvanism. There was, however, distinct atrophy of all the interossei, and when full extension of the hand was attempted, some hyperextension was noted at the metacarpophalangeal joints, along with less complete extension than normal of the two distal phalanges, this condition being more distinct in the little and ring fingers. The appearance of the hand was that of the typical ulnar nerve lesion, though not in pronounced degree. What had happened was that the deep branch of the ulnar nerve, traversing the palm of the hand from ulnar side to radial just proximal to the heads of the metacarpals, was the seat of a traumatic neuritis, the result of direct pressure.

Blastomycotic Abscess of Brain.—Moore reports a case in which death resulted from abscess of the brain. The infection in this case was probably introduced through the mouth from the splinters habitually carried in the mouth. The infection of the brain was possibly through the ophthalmic vein or through the veins of the scalp and emissary vein through the skull. The study of the organisms in the different lesions and tissues showed a considerable variation in their size; those from the abscesses of the face, neck and orbit, showing the large forms, while no large forms could be found either in the pus or the tissue from the brain.

Cure of Subphrenic Abscess.—Ullman and Levy report the case of a patient who developed a subphrenic abscess while under hospital supervision; the patient having been operated on for a pelvic appendiceal abscess which was walled off and from which about 3 quarts of pus were evacuated. The roentgenologic findings were those of an abscess with gas formation.

Retroperitoneal Sarcoma.—Two cases are reported by Trout and Meekins and a review is made of the literature on retroperitoneal sarcoma to April 1, 1920.

Finger and Toe Nail Extension.—To make use of finger or toe nail extension, small hole is bored through the center of the nail, just beyond the skin, care being taken not to injure the soft tissues or cause any hemorrhage under the nail. Through this hole is drawn a strong silk thread.

Use of Psoas Parvus Tendon in Prolapse of Uterus and Rectum.—In the methods described by Bryan the psoas parvus tendon is used to pull up on the round ligament by being carried around it, thus holding up the uterus. In cases of rectal prolapse it is sutured into the longitudinal line of the rectum.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Single case reports and trials of new drugs are usually omitted.

British Medical Journal, London

Nov. 20, 1920, **2**, No. 3125

Orthopedic Surgery in Relation to Hospital Training. R. Jones.—p. 773.
*Ulcerating Granuloma of Pudenda Cured by Intramuscular Injections of Antimony Tartrate. H. L. Cumming.—p. 775.
*Seven Cases of Essential Pentosuria. P. J. Cammidge and H. A. H. Howard.—p. 777.
*Treatment of Cutaneous Erysipelas with Brilliant Green. J. E. Adams.—p. 779.
*Intravenous Protein Therapy in Epilepsy. F. H. Edgeworth.—p. 780.
Pathology of Dementia Praecox. F. Mott.—p. 781.
Lethargic Encephalitis. E. F. Buzzard and J. G. Greenfield.—p. 782.
Sensory Disturbances in Hand Following Injuries of Cerebral Cortex. H. Head.—p. 782.
Degeneration and Regeneration of Peripheral Nerves. J. G. Greenfield.—p. 783.
Inscriptions of Speech. E. W. Scripture.—p. 783.

Antimony Tartrate in Ulcerating Pudendal Granuloma.—In Cumming's case about 3 grains of antimony tartrate were injected intramuscularly over a period of thirty-six days. Only twelve injections were given. Cumming began with 9 minims (about ½ grain) antimony tartrate, and gradually went up to 1.2 c.cm., or ⅛ grain, antimony tartrate, for the last five injections. By mouth, roughly, from 27 to 30 grains of antimony tartrate were taken over the same period. How much of the care can be attributed to the oral administration of the drug is difficult to calculate, but it was noted that although the patient was taking from 5 to 20 minims of antimony wine three times a day, in gradually increasing doses, for a period of seventy-one days, without any appreciable effect on the condition of the sore, it is reasonable to conclude that only a very small amount of the drug subsequently given by mouth, had any definite effect on the process of healing. On the other hand, very definite improvement took place after the fourth intramuscular injection, that is before the drug given orally could have had time to have much constitutional effect. All other local treatment was suspended while the injections were being given, with the exception of an antiseptic wash, night and morning, for the sore, followed by the application of a little dusting powder composed of equal parts of calomel, boracic acid, and iodoform, which had been previously used without the slightest effect.

Essential Pentosuria.—Five of the cases seen by Cammidge and Howard proved to be examples of simple essential pentosuria, inactive arabinose being the only sugar present in the urine; in the remaining cases small quantities of dextrose and pseudo-levulose were found in addition. One of the patients with pure pentosuria had been treated for diabetes for twenty-six years, two patients had been dieted along orthodox lines for the same complaint without any improvement for several months, a fourth patient was referred as a case of lactosuria, presumably because the sugar in the urine did not ferment with yeast, and in the fifth patient the presence of sugar had been discovered accidentally, although its nature was not determined, previous to an operation. The remaining two patients had been rejected for life insurance owing to the presence of glycosuria.

Brilliant Green in Erysipelas.—Picric acid, iodin and brilliant green have been tried by Adams and his associates in parallel cases of about the same degree of virulence and all favor brilliant green. In a dozen cases so treated the average time for subsidence of the attack was just over five days. There has been no mortality in the whole series of forty cases, but recrudescence occurred in two cases, once on the tenth and once on the twelfth day. The method has been to paint the affected area with a 5 per cent. aqueous solution once a day in mild cases and twice a day in severe cases. No dressing has been applied, except a piece of lint on some parts of the body to prevent staining of the bedclothes. When the eruption has subsided the discoloration can be removed in three or four days by vigorous washing, preferably with ether soap.

Intravenous Protein Therapy in Epilepsy.—In a series of twenty-three cases of epilepsy a 5 per cent. solution of peptone was used, made up according to the prescription of Auld; that is, dissolve the peptone in three-fourths of the required volume of physiologic sodium chlorid solution, shaking and warming to 37 C. Add 1 c.c. of a 2 per cent. solution of sodium-carbonate for each 5 grains of peptone present. Make up volume by adding more salt solution. Add phenol, so that its percentage in the solution is 0.25. It was injected into a vein at the elbow once a week. The initial dose was 5 minims. In succeeding weeks 7, 10, 15 and 20 minims were given unless toxic symptoms occurred. No dose greater than 20 minims was injected. If a fortnight went by without the occurrence of a fit, the dose was not further increased. If no results were obtained after three doses of 20 minims the treatment was given up. In four cases toxic symptoms were observed, rigor, vomiting, temporary pyrexia, either as an isolated phenomenon, or in any combination. If this happened, the next dose was lessened. In such cases it was found that the dose could be increased later to the old figure or even beyond without the occurrence of any untoward symptoms. In three cases of posthemiplegic epilepsy no improvement occurred. In eleven cases of epilepsy without signs of any gross cerebral lesion no permanent arrest was produced. In eleven cases of epilepsy without signs of any gross cerebral lesion no permanent arrest was produced. In four of these the fits ceased but subsequently recurred, though in lessened severity, and in two cases the frequency was lessened. The average age of the patients was 18 years, the average duration of the disease ten years, and the average frequency of fits once a week. In nine cases of epilepsy without physical signs of any gross cerebral lesion the fits ceased. This arrest has now lasted more than a month in all cases, and in some as long as three months. Five of the patients were mentally defective—in one of these cases no mental improvement occurred, in three some improvement, and in one considerable improvement was noted. The average number of injections given was five and one-half.

Bulletin Naval Medical Association, Tokyo, Japan

November, 1920, No. 31

Urea and Amino-nitrogen in Blood and Urine of Beri-Beri. K. Shinkai.—p. 1.
*Experiments Concerning Antiscorbutic Property of Some Food Stuffs in Japan. T. Koga.—p. 2.

Antiscorbutic Property of Foods.—Koga made a series of animal experiments with the purpose of finding foodstuffs which could be preserved without losing their antiscorbutic property. Guinea-pigs were fed on bean cellulose mixed with foodstuffs selected for examination. When 15 gm. cabbage were given daily with bean cellulose, the animals were healthy up to the forty-first day of the experiment, while animals fed exclusively on bean cellulose were generally attacked on the fifteenth day by a morbid condition resembling scurvy and died on the twenty-fourth day. Pickled radish, pickled plums, bean paste, salt pork and salted salmon could not protect the animals from the disease. Twenty gm. sprouting red beans, given daily, had an antiscorbutic effect like cabbage. The red beans could be stored for a long time and easily be sprouted at any time by suitable moisture and warmth.

Journal of Tropical Medicine and Hygiene, London

Nov. 15, 1920, **23**, No. 22

Asiatic Cholera in Syriam Municipality, Burma, in June-July, 1920. J. C. Tull.—p. 273.
Some Infections Due to Freshwater Snails and Their Eradication. F. G. Cawston.—p. 274.

Archives Médicales Belges, Liége

June, 1920, 73, No. 6

*Basal Metabolism. A. M. Snell, F. Ford and L. G. Rowntree.—p. 467.
*Bronzed Diabetes. H. Koettlitz.—p. 494.
The Diphtherin Skin Reaction. J. Michiels.—p. 506.
The Ration of the Belgian Soldier. F. de Block.—p. 509.

Basal Metabolism.—This is a translation of a paper read at the last meeting of the American Medical Association and published in THE JOURNAL, Aug. 21, 1920, p. 515.

Bronzed Diabetes.—Koettlitz describes a case in a man of 57 which proved fatal in five months. The main features were the rapid and progressive cachexia, asthenia, bronzed jaundice, with enlargement of the liver, especially of the right lobe, polyuria, and diabetes, with continuous slight fever, but the liver region was not tender. From the necropsy findings in such cases he explains the condition as a general dystrophy of the cellular elements of the body from loss of the ability to consume carbohydrates, plus the acquisition of two abnormal properties, namely the faculty of attracting the pigment of the blood, and the faculty of increase in connective tissue which assumes, particularly in the liver, the aspect of pronounced interstitial inflammation. The liver is found pathologic in from 35 to 60 per cent. of cases of diabetes, but the bronzing is not the work of the liver or the diabetes. One or the other of these three may predominate, such as the hepatitis in Murri's case, the diabetes in Letulle's and de Foax' cases, and the hemochromatosis as in Hoppe-Seyler's and the case here reported.

Bulletin de l'Académie de Médecine, Paris

Oct. 12, 1920, 84, No. 31

Anemia from Multiple Infections in Indo-China. A Thiroux.—p. 130.
*Test for Lactic Acid in Organic Fluids. E. Pittarelli.—p. 132.

Test for Lactic Acid.—Pittarelli states that in organic fluids only lactic acid, ethyl alcohol and mannite yield acetic aldehyd when in contact with potassium permanganate. On this he bases a sensitive test for the presence of lactic acid. His reagents are saturated solutions of the permanganate, of phenylhydrazin hydrochlorate, of diazosulphanilic acid and of magnesium sulphate, with a 30 per cent. solution of sodium hydroxid. The lactic acid is transformed into acetic aldehyd by the permanganate, kept constantly neutral by addition of the magnesium sulphate. Then adding to the filtrate the other reagents in turn reveals the acetic acid by the bright red tint.

Nov. 2, 1920, 84, No. 34

*Spurious Tuberculosis of Psychopathic Origin. M. de Fleury.—p. 179.
*Auscultation of the Digestive Canal. G. Hayem.—p. 184.
Physical Signs of Closed Pneumothorax. E. Rist.—p. 199.

Spurious Tuberculosis of Psychopathic Origin.—De Fleury refers to progressive emaciation, agitation, anorexia, insomnia and spasmodic constriction of the esophagus and of the respiratory apparatus, without fever, as forming a clinical picture liable to be mistaken for tuberculosis. The variable tachycardia, moist palms and night sweats confirm its nature as an emotive psychoneurosis. There may be a dry cough but when the attention is diverted there is no coughing. Tonics only aggravate the condition. Treatment has to be addressed to calm the agitation and conquer the spastic anorexia and the insomnia, with repose as for true tuberculosis.

Auscultation of the Digestive Tract.—Hayem discusses in turn the information to be derived from the sounds heard in the pharynx, esophagus, stomach, intestines and peritoneum and the transmitted sounds. Subacute and chronic peritonitis may yield sounds like those heard in pleurisy. One unexpected discovery was the frequency of tympanism of the stomach from swallowing of saliva produced in excess. He ascribes ordinary flatulence in most cases to the air swallowed with the saliva in this sialophagia, but in other cases gas is generated in the stomach itself, even in normal conditions.

Bulletin Médical, Paris

Nov. 6, 1920, 34, No. 52

*Hydropneumothorax with Small Effusion. C. Mantoux.—p. 979.
*Thornwaldt's Disease. Baillet.—p. 979.

Diagnosis of Small Effusion with Hydropneumothorax.—Mantoux bends the patient's trunk far back to collect the effusion in the culs-de-sac where it can be detected by the dulness on percussion. When this fails, he has the patient bend far forward and then bend abruptly backward. The effusion is thus thrown abruptly back, and the ear on the watch can detect its presence.

Thornwaldt's Bursitis.—Baillet expatiates on the evils almost inevitably following pus in Luschka's tonsil, and urges prompt curetting with a small curet after exploring the region with the finger to ascertain the shape and depth of the cavity.

Journal de Médecine de Bordeaux

Sept. 25, 1920, 91, No. 18

*Myxedematoid Pains in the Legs. H. Verger.—p. 487.
Tuberculosis of Uterine Cervix. Verdelet and Daraignez.—p. 491.
Hygroma of Prepatellar Bursas. A. Baudrimont.—p. 493.
Large Doses of Tincture of Iodin Internally. L. Boudreau.—p. 495.

Myxedematoid Pains in the Legs.—Verger refers to pains accompanying changes in the skin suggesting myxedema. Both are inclined to be chronic, the pains in leg, knee or thigh coming on during walking and standing, but sometimes also during repose, but they are never paroxysmal. Rheumatism or internal varices is the usual diagnosis; analgesics by the mouth have little or no effect. Rubbing aggravates the pains, and elastic stockings cannot be borne. The pains are usually bilateral but may suggest sciatica on one side. There is tenderness on the back of the thigh, at the bend of the knee and at the ankle, and Lasègue's sign is positive. The skin and subcutaneous tissue are the seat of the pain, not the path of the nerve. The patients have always been females, and the pain on squeezing a fold in the skin differentiates the type. The differential diagnosis is confirmed by the success of endocrine therapy, especially thyroid treatment. It has to be long and persevering, but the benefit from it far surpasses that from any other treatment tried to date. Among his patients was one woman of 45 with this left pseudosciatica and pronounced myxedematous state which had developed six months before. No benefit was apparent under thyroid treatment until after seven months, but in five months more she was completely cured. He gives it for twenty days each month.

Oct. 25, 1920, 91, No. 20

Prophylaxis of Scoliosis in the Young. J. Gourdon.—p. 539.
Suppuration of Simple Fracture. R. Villar.—p. 541.
*Aerophagia and Vomiting in Infants. Dargein.—p. 542.

Aerophagia.—Dargein fastened the infants' sleeves or hands to prevent their sucking fingers, and had an attendant watch two infants at a time during the bottle feeding so that the nipple did not slip out of the mouth; the bottle was also removed the moment the last drop had been taken. A little sodium bromid was given the more restless infants. By these means aerophagia was warded off, and there were no more "big bellies" among the infants. The infants that kept on sucking after the bottle was withdrawn were given a little more food until fully satisfied.

Vomiting Infants.—Conquering the aerophagia put an end to the incessant vomiting of some of the infants, but others vomited with surprising regularity and tenacity until Dargein gave them one drop of 1:1,000 solution of atropin before each bottle. This arrested the spasm of the stomach responsible for the vomiting in certain cases. Those with putrid stools or diarrhea were given treatment according to the chemical findings in the stools. When there was evidence of a sluggish liver, with putrid stools, great benefit followed the use of abundance of kefir. The kefir proved life-saving also for several prematurely born infants with defective nutrition. The kefir was prepared in the institution.

Paris Médical

Oct. 23, 1920, 10, No. 43

Proofs of Acquired Immunity to Influenza. C. Dopter.—p. 289.
The Campaign Against Malaria in Algeria. L. Brodier.—p. 293.

Oct. 30, 1920, 10, No. 44

*Meningococcus Purpura. P. Lereboullet and J. Cathala.—p. 305.
Diagnosis of Cancer of Rectum. R. Savignac.—p. 307.
Training Stump for Permanent Prosthesis. Roederer.—p. 313.
Auto-Observation of Lethargic Encephalitis. Delater.—p. 316.

Purpura in Meningococcus Septicemia.—Lereboullet and Cathala as well as Netter have noticed that cerebrospinal meningitis of recent years has often assumed a septicemic and purpuric character. It may seem to be merely an ordinary infectious purpura until the meningitis develops; it is usually fatal in such cases. In a case described the meningococcus was not suspected although the pains in the spine, sudden onset, headache and retention of urine might have warned that the purpura was atypical. The diagnosis for five days was simple rheumatoid purpura, apparently confirmed by defervescence, but two days later fulminating meningitis developed. The case reaffirms the necessity for seeking for the meningococcus in every case of primary purpura. The spinal fluid may be clear at the first puncture and yet be swarming with meningococci; the purpura is the work of the septicemia, and the meninges may not be involved at first. Meningococci may exceptionally be detected in the fluid from a patch of purpura or from a suppurating joint or choroiditis, but even if it is not possible to isolate them, no time should be lost in giving an intramuscular injection of antiserum, injecting it likewise into the spinal canal. It came too late to save the young woman in the case here described.

Presse Médicale, Paris

Nov. 3, 1920, **28**, No. 80

*Excessive Functioning of the Parotids. P. Dalché.—p. 785.
*Appendicular Asthma. R. A. Gutmann.—p. 787.
Gangrenous Process in Angina Ludovici. E. L. Peyre.—p. 789.

Enlargement of the Parotid Glands at the Menopause.—In one of the two cases reported by Dalché, the parotid and submaxillary glands enlarged and subsided again alternately every month or two, but in the other the enlargement was chronic and accompanied symptoms suggesting exophthalmic goiter. The enlargement of the salivary glands had accompanied the woman's two pregnancies, but never at other times until the menopause became installed. Other data cited confirm this connection between the salivary and the endocrine glands, and suggest the possibility of organotherapy. As such cases usually present evidence of deficient ovary or testicle and thyroid functioning, thyroid treatment might be tried or other gland extracts, alone or combined, supplemented possibly by radiotherapy, with treatment for syphilis if there is any hint of this disease.

Reflex Asthma.—The form discussed by Gutmann is that accompanying appendicitis. The diseased appendix charges the battery, but some casual toxic action presses the button that starts the attack. This may take the form of migraine, sciatica, vertigo, excitement or asthma according to the predisposition. It may even simulate pulmonary tuberculosis.

Progrès Médical, Paris

Sept. 25, 1920, **28**, No. 39

Management of Delivery with Deformed Pelvis. L. Cleisz.—p. 419.
Chronic Jaundice. Lereboullet.—p. 423.
*Luminal in Treatment of Epilepsy. H. Codet.—p. 425.

Luminal in Epilepsy.—Codet reviews the results of treatment with phenobarbital (luminal), of sixteen epileptics several months ago and of fifteen more recently. The work issues from Maillard's service; a previous report from the latter was reviewed in these columns, Sept. 25, 1920, p. 902. The doses found most suitable were 0.3 gm. per day for two days and then 0.2 gm., returning to the larger dose if the seizures are not attenuated, and reducing the dose if there is disquieting torpor. Sometimes it was found useful to alternate these doses, giving 0.2 one day and 0.3 gm. the next. The doses must always be fractioned, and this treatment should never be stopped abruptly. Hot baths might be useful in case of excitement, and a tonic if the torpor is too profound and the pulse is weak. The above doses are for adults.

Oct. 2, 1920, **28**, No. 40

*Migraine. G. Didsbury.—p. 429.
Lecture on Impermeability of the Kidneys. Loeper.—p. 431.
Fel Bovis in Therapeutics. G. Faroy.—p. 436.

Oct. 9, 1920, **28**, No. 41

Emphysema of Nontuberculous Origin. C. Roubier.—p. 439.
Hermaphrodism and Sexual Inversion. Laignel-Lavastine.—p. 441.
Sodium Salicylate. G. Faroy.—p. 444.

Oct. 16, 1920, **28**, No. 42

Ovarian Cyst and Pregnancy. J. Stiassnie.—p. 451.
Alkaptonuria. Lereboullet.—p. 452.
Ipecac and Emetin. G. Faroy.—p. 454.

Treatment of Migraine.—Didsbury comments on the restriction of the pain in migraine to one side of the head, the spasmodic, radiating pains, and the vasomotor disturbances, ascribing the whole to a local, superficial hyperesthesia, although the provocative factor may be a reflex from stomach, ovary, organs of sense, or elsewhere. The points of hyperesthesia are found along the superficial nerves of the back of the neck, of the skull and of the face, and especially at the emerging points of these nerves. These painful points can be located during quiescent periods, between attacks, and the physiologic treatment is to put an end to the hyperesthesia. This, he says, can be accomplished by massaging the points of hyperesthesia between the thumb and other fingers. The massage should be repeated daily for half an hour at a time; it is painful at first but grows less so. After fifteen sittings, on an average, the patient sleeps better, the migraine recurs less frequently, and the pain is less intense and of shorter duration, and yields to measures previously ineffectual. Children and thin persons are the best subjects, and it may be wise to apply the massage once a year. An old chronic case is naturally hardest to cure.

Schweizerische medizinische Wochenschrift, Basel

Nov. 4, 1920, **50**, No. 45

*Three Years' Measurements of the Thyroid. H. Hunziker.—p. 1009.
*Accidental Wounds and Infections. J. Dubs.—p. 1014.
Lumbar Puncture in Lethargic Encephalitis. R. Fritzsche.—p. 1018.
Conc'n in No. 46. p. 1045.
Calorimeter Estimation of Mountain Climate. E. Peters.—p. 1022.
Congenital Diverticulum in Small Intestine. A. Glaus.—p. 1024.

Food as Responsible for Goiter.—Hunziker added 1 gm. of potassium iodid to the barrel containing the fertilizer for his vegetable garden. In this way from 17 to 22 gm. potassium iodid were distributed over the garden, 300 and 1,200 square meters in extent, in the course of the season, and no vegetables or rhubarb, etc., from other source were used in the family. The circumference of the neck of his five children was recorded systematically during the three years of the experiments, and also the measurements of a corresponding group from another family not getting the iodized vegetables. He says of his experiences: "Herewith I have demonstrated that the food by its greater or less iodin content must have a capital influence on the prevalence of goiter in a community. . . ." "Of at least equal importance is the local and familial combination of foods for the daily dietary." Of special interest was the abrupt decline in the size of the neck in the noniodized group in a certain month. There had been no change in the conditions in any way except that the mother was employed at that time at a community kitchen, and she fed her children there, which meant almost exclusively on soup, a complete change from their previous home diet. This he cites as "drastic evidence of the dependence of the size of the thyroid on the nature of the food."

Common Blunders in Treatment of Wounds and Infections.—Speaking to general practitioners, Dubs emphasizes that crushed and torn tissues scarcely ever heal by primary intention, however early the surgeon gets the case. Primary suture can be attempted when the wound is on the scalp, eyelids or face, to ward off disfigurement, but we must appreciate the risk we are taking, and supervise the case with special care. Under all other circumstances primary suture should not be attempted unless we can count on having excised every atom of devitalized tissue. "For the present, it is safer for the general practitioner to suture too seldom than too often." He adds that we can always amputate or exarticulate, but we can never bring back a too hastily sacrificed segment of a finger or skin flap. He advises to trephine the nail for a hematoma below, and not try to reach it from the edge of the nail. The warning against seeking to extract foreign bodies in an office consultation is reiterated. Even with the aid of the roentgen rays it is by no means an easy task, and yet needles, scraps of metal, bullets, etc., often seem so accessible that the practitioner cannot resist the temptation to seek to

remove them by a simple incision. He usually succeeds only in driving them farther in and out of reach.

There is still a difference of opinion in regard to the wisdom of early incision for phlegmons and felons, but Dubs insists that the practitioner should make it his rule to incise at once if the symptoms from the felon do not show signs of retrogressing under twelve or twenty-four hours' passive hyperemia. He adds that a convenient means for inducing passive hyperemia is with an ordinary rubber cot drawn over the finger. Its base provides just the right amount of constriction for relief of pain in the throbbing finger. Many an incipient paronychia has been thus aborted. Local anesthesia is advised for the incision of a felon. "The local anesthesia may be one of the imponderables which explain So-and-so's larger practice." Notwithstanding the dorsal appearance of the lesion, the necrotic focus is always volar, and the unconditional early incision is the best means to arrest it. It is important further to go over the entire finger and the hand with a probe every day, at every change of dressings, to detect any tender point suggesting involvement of tendons, and to incise at once when such is detected. Multiple incisions at the side are better than a median incision, with a loose strip of gauze drawn through to drain, and long hot baths of soft soap after the incision, always bearing in mind that the "treatment of a tendon sheath panaritium is the treatment of the sound fingers."

Policlinico, Rome

Sept. 27, 1920, **27**, No. 39

*Etiology of Lethargic Encephalitis. D. Ottolenghi, S. d'Antona and F. Tonietti.—p. 1075.
*Acute Myelitis. L. Schiboni.—p. 1081.
Typhoid in the Vaccinated Troops. C. Garosci.—p. 1085.

Etiology of Lethargic Encephalitis.—Ottolenghi and his co-workers report findings which confirm those of Maggiora in respect to the filtrability of the virus found in the blood and spinal fluid of patients with lethargic encephalitis, and that this virus will transmit the disease to guinea-pigs when injected into the peritoneum or brain. The disease is also contagious for guinea-pigs when washings of the nasopharynx are instilled in the nostrils. This occurs also in rabbits, but only when the nasal mucosa has been first scarified. Cats are also susceptible, and the brain substance of the infected cats is virulent for the guinea-pig. The bacteriologic findings were constantly negative except in one case in which a streptodiplococcus was found resembling that described by Wiesner in 1918. They have now two strains of virus which have stood twelve and eight passages. The experimental disease lasted for from five to thirty-five days and proved fatal in all but thirteen of the 215 guinea-pigs inoculated.

Acute Myelitis.—Schiboni has recently encountered some cases of ascending spinal paralysis which are evidently forms of lethargic encephalitis. This latter disease has been epidemic at Rome but seems to have died out there now, but is still prevailing in other regions. He describes a case in a student, fatal in six days.

Riforma Medica, Naples

Aug. 28, 1920, **36**, No. 35

*Abrams' Splenic Reflexes. L. Scalas.—p. 781.
*Cultivation of Rabies Virus. R. Pirone.—p. 782.
Primary Sarcoma of Descending Colon. S. Dalmazzoni.—p. 784.
Bacteriology of Lethargic Encephalitis. Durand.—p. 789.
Rational Treatment of Urethral Stenosis. D. Taddei.—p. 790.

Abrams' Splenic Reflex.—Scalas writes that his attempts to elicit the splenic reflex, according to Abrams, in nine children and ten adults were negative, except in five children in whom there was a slight increase in the mononuclears and transitional forms compared with the count before and after the percussion of the spine. But in no instance was a febrile attack elicited, or the parasites appeared in the blood. It is possible, however, that the spleens were too pathologic to respond, as Cagliari is a hotbed of malaria.

Cultivation of Rabies Virus.—Pirone tabulates his findings with rabies material kept in glycerin. He was able to cultivate the virus through three generations.

Sept. 4, 1920, **36**, No. 36

Pathologic Anatomy of Lethargic Encephalitis. P. Guizzetti.—p. 806.
*Acute Form of Fibrous Bronchiolitis. D. de Conciliis.—p. 814.
*Diffuse Neurofibromatosis. G. Castronuovo.—p. 817.

Acute Form of Fibrous Bronchiolitis.—De Conciliis refers to the necrotic process in the bronchioles which follows gassing.

Diffuse Neurofibromatosis.—Castronuovo's patient, a man of 34, succumbed to pulmonary tuberculosis. The diffuse neurofibromatosis had developed at about the same time as the tuberculous process. The onset had been accompanied with asthenia, subnormal blood pressure, diarrhea and gastric disturbances, and zones of pigmentation of the skin. Under epinephrin treatment, marked improvement in these symptoms was realized but the lung process progressed unmodified. Endocrine therapy, arsenic and thiosinamin are the main reliance in Recklinghausen's disease, with excision of tumors causing compression or suggesting malignant degeneration.

Anales de la Facultad de Medicina, Montevideo

July-August, 1920, **5**, No. 7-8

*The Pulmonary Heart. Olinto de Oliveira.—p. 297.
*Pathologic Anatomy of Pulmonary Syphilis. P. I. Elizalde.—p. 315.
The Interning of the Insane. B. Etchepare.—p. 340.
Lethargic Encephalitis. A. Ricaldoni.—p. 353.
*Entero-Bacteriotherapy. E. M. Claveaux.—p. 411.
Chronic Postpartum Inversion of Uterus. M. Becerro de Bengoa.—p. 436.
Anatomy of the Muscles of the Thumb. F. Abente Haedo.—p. 445.

The Pulmonary Heart.—By this expression is meant the disordered heart action from disturbances in the venous cardiovascular system for which some patch of sclerosis entailed by a chronic tuberculous or other process in the lung is responsible. The symptoms from the heart in these cases form a special clinical type, extremely slowly progressive but leading up finally to auricular fibrillation and asystole. The history of the case shows the preceding pulmonary lesion although it may be latent or clinically cured, and the impeded circulation. The apex beat is weak; there is pulsation in the epigastrium, and the area of dulness is enlarged around and to the right of the heart, with double rhythm and other signs of dyschronia, dilatation or hypertrophy of the right ventricle; arrhythmia; low arterial tension; increased venous tension but no edema as a rule; changes in the size of the veins; dyspnea continuous or only after effort and without orthopnea, and oliguria without albuminuria but with lower tension coefficient. Fatigue starts a vicious circle. Oliveira does not know of any previous attempt to correlate auricular fibrillation with fibrous degeneration of the lung.

Pulmonary Syphilis.—Elizalde describes a case with multiple syphilitic lesions in the lungs which seemed to offer every variety and grade of the lesions and changes which syphilis is capable of inducing. He compares them with the findings in seven years' study of syphilitic cadavers.

Enterobacteriotherapy.—Clavaux accepts Danysz' dictum that the intestinal flora plays the preponderant rôle in chronic pathologic conditions, and that it does this by a kind of anaphylactic sensitization of the organism. This conception permits causal treatment by anti-anaphylaxis with an autovaccine, and he reports the outcome in fourteen cases from his extensive experience with eczemas, psoriasis, dermatitis of various origin, prurigo, etc., as well as in asthma, mental derangement, colitis, and inveterate constipation. Pruritus with skin diseases was almost invariably favorably modified and the outcome was very good in the eczema and prurigo cases even in cases of several years' standing. In some cases the suppurating itching disease over practically the entire body, refractory to all treatment, from unguents to radium, healed in the course of three or four weeks under the enterovaccine. Recurrence was not infrequent, but it was milder and yielded anew to the treatment. He gives illustrations showing the remarkable improvement in a case of diffuse dermatitis exfoliativa of twenty-four years' standing in a young woman, and in a girl of 10 with diffuse, fetid, weeping eczema for nine years. Another patient was a man of 64 with actual pachydermia for five years. Under twenty daily subcutaneous injections of 1 c.c. of the autovaccine, the infiltration inducing the pathologic hardening subsided almost completely.

Sometimes no benefit was apparent until twenty or thirty injections had been made, or even not until after the close of the course. He was impressed with the prompt preventive action when the vaccine was injected at the early signs of recurrence. Habitual constipation is usually favorably influenced, but in one case no improvement was evident even after two courses of the treatment. He refers constantly to Danysz' communications. They were summarized in these columns April 10, 1920, p. 1054.

Brazil-Medico, Rio de Janeiro

Aug. 21, 1920, 34, No. 34

*Respiration as Defense Against Heat. M. Ozorio de Almeida.—p. 545.
Carcinoma of the Prostate with Metastases in Bones. Clark.—p. 546.
Seasickness. J. Drummond.—p. 548.
Aneurysm of Aorta. Thibau Junior.—p. 550.

Aug. 28, 1920, 34, No. 35

Hodgkin's Disease at Bahia; Two Cases. O. Torres.—p. 565.
Brazilian Leeches. C. Pinto.—p. 567.
Organized Welfare Work for Children. Moncorvo, Jr.—p. 574.

Sept. 4, 1920, 34, No. 36

Epidemic Encephalitis; Three Cases. C. de Rezende.—p. 585.
Appendicular Peritonitis. J. S. Passeron.—p. 590.
Nomenclature of Fungi. J. Silvado.—p. 591.

Thermic Exaggeration of Respiration.—Ozorio refers to the panting of dogs when heated, as they thus expel the moisture which in man passes off in sweat. The breath of dogs in these conditions is saturated with moisture and the breathing rate may reach 300 per minute. The Hering and Breuer reflexes cannot be elicited during this thermic polypnea.

Sept. 18, 1920, 34, No. 38

*Histopathology of Senile Dementia. U. Vianna.—p. 621.
The Hookworm Campaign. J. de Barros Barreto.—p. 621.
Some Brazilian Leeches. C. Pinto.—p. 624.
Marriage from Eugenics Standpoint. R. Kehl.—p. 626.

Histologic Findings in Senile Dementia.—Vianna presents evidence to show that the histopathology of senile dementia runs a cyclic course from the neurofibrillar changes) Alzheimer) in the horn of Ammon to patches (Redlich-Fischer) in the cortex; then patches in the horn of Ammon, and finally neurofibrillar changes in the cortex.

Revista de la Asoc. Médica Argentina, Buenos Aires

April-June, 1920, 32, No. 186-188

Cerebral Polyuria in the Rabbit. J. C. Galán.—p. 57.
Protosystolic Enlargement of Heart. B. A. Houssay et al.—p. 60.
Histamin Antagonistic to Epinephrin. J. B. Llosa.—p. 62.
*Action of Snake Venom. C. F. Velarde and J. Miravent.—p. 64.
*Sarcoma of the Pituitary. A. Sacco and Delfor del Valle.—p. 53.
*Acute Postoperative Peritonitis. P. Escudero.—p. 66.
*Radiography of the Sella Turcica. C. Donovan.—p. 72.
*Reflexions on Tuberculosis. J. J. Vitón.—p. 95. Cont'n.
Gas Gangrene of Appendicular Origin. P. Chutro.—p. 105.
*Rheumatismal Nodes. J. C. Navarro and E. Beretervide.—p. 112.
*Endocrine Dwarf Growth. M. R. Castex and C. P. Waldorp.—p. 126.
*Complications of Inherited Syphilis. T. Padilla.—p. 162.
*Spirochetal Bronchitis. R. A. Vaccarezza.—p. 173.
Auricular Bigeminal Beat. R. A. Bullrich.—p. 182.

Snake Venom.—The venom of the various snakes investigated contracts the isolated uterus and intestine of rabbits. It thus affects smooth and striated muscle alike, but a concomitant action on the nerves is evident. The contracting influence and the toxicity of the venom did not seem to parallel each other.

Sarcoma of the Pituitary.—Sacco and Delfor del Valle removed a round cell sarcoma from the pituitary of a woman of 28 restoring her to active life, free from symptoms during the nine months since, except a well tolerated glycosuria which has developed since. Ten illustrations show the access through the brow and the intracranial and photomicrograph findings. Menstruation had not returned after the birth of a healthy child, and within the year left frontal headache developed, keeping up night and day, with fluctuations in intensity but never complete freedom during four and a half years. At the third year she noticed that hands and feet were growing large and there were attacks of vomiting. At the operation the curving incision in the eyebrow and the parallel incision in the edge of the hair were connected by a perpendicular incision on the median line, and this allowed ample access. The tumor was drawn out whole with a vacuum suction glass, and weighed 5 gm. The technic was simple and easy.

Acute Postoperative Peritonitis.—Escudero reported in 1918 three cases of fatal postoperative obliteration of the mesenteric vessels. He here reports a fourth case but he operated at once and corrected conditions in the mesenteric vessels. The diagnosis was based on the intense pain experienced on rousing from the anesthesia, keeping up day and night, rebellious to morphin, with hiccup the second day, persisting for sixteen hours, tachycardia to 120, paralysis of the intestines but no physical signs of peritonitis till the thirty-sixth hour, and no rise in temperature. The operation for duodenal ulcer had shown that the diffuse arteriosclerosis involved the mesenteric vessels. The laparotomy at the fifty-second hour confirmed the assumption of defective circulation in mesenteric vessels but it had not progressed to mortification, and under stimulants and drainage the disturbances subsided. There was abundant profuse melena after this second intervention, but the health has been good during the year since. In all four cases there was a history of syphilis.

The Sella Turcica.—Roentgenograms are given of seven cases, including some with tumor, and one idiot.

Reflexions on Tuberculosis.—Vitón discusses in this instalment the sets of symptoms from endocrine derangement for which the tubercle bacillus is responsible. He asserts that the functions of any and every organ may suffer the consequences of an intoxication at some remote point, with or without the organs showing visible changes. There is a wide range between the typical lesions and syndrome of Addison's disease with its well defined tuberculous lesions, and the suprarenal asthenia symptomatic of a tuberculous lesion in some other organ. A chronic character is more readily accepted as the attribute of tuberculous and syphilitic infection, but acute pathologic conditions are likewise traceable at times to this etiology, and may benefit by treatment for one or the other. He reports further some cases in which under tuberculin treatment by his method of minutest doses, excessive thyroid functioning was reduced to normal. The weight is the most reliable gage of the improvement in hyperthyroidism. The thyroid retrogressed, but never completely in his cases.

Rheumatismal Nodes.—Navarro and Beretervide do not regard the nodes as pathognomonic of rheumatism but it is certain that the latter is the habitual if not the exclusive cause. They have never found them unless the rheumatism had attacked the heart, and then only in the severer cases. The nodes call for intensification of the treatment. In one of their three cases in children of 11 and 13, salicylate treatment by the vein and by the mouth was kept up for seven months with slow improvement but final apparent complete recovery, even the heart functioning seemingly normal, and the child increasing 10 kg. in weight. The extremely numerous nodes persisted for three months. The girl of 11 was given by the mouth in four months 130 gm. of the salicylate besides intravenous injections with a total of 9.5 gm. They ordered the treatment discontinued then, but the parents continued it for three months longer, thirty-two injections by the vein with a total of 16 gm. She seems now the picture of health.

Endocrine Dwarf Growth.—Forty-two illustrations accompany this report with necropsy findings of a female dwarf of about 25, with inherited syphilis, multiple malformations of bones and viscera, Raynaud's disease and dementia praecox.

Congenital Heart Defect.—Padilla's patient presents besides the congenital heart defect, hemolytic jaundice, cirrhosis of the liver with hypertrophy, pluriglandular dysfunction of several of the endocrine glands, and backward growth, on a basis of inherited syphilis.

Spirochetal Bronchitis.—Vaccarezza has been examining for spirochetes all the specimens of sputum sent to the laboratory, seeking for evidence of pulmonary syphilis. He found spirochetes in one case in which there had been recurring hemoptysis during four years without modification of the general health. The physical signs suggested echinococcus disease, but the spirochetes differentiated it as Castellani's bronchospirochetosis. On account of the spitting of blood, these cases

are generally classed as tuberculous. As the spirochetosis is contagious, isolation is necessary. A cure was realized in his cases and in a number on record under iodized oil, up to 10 c.c. daily for ten days or more, continuing then the iodin treatment by the mouth.

Semana Médica, Buenos Aires

July 1, 1920, 27, No. 27

The First Cases of Epidemic Encephalitis Were Published in France April 27, 1917. R. Cruchet.—p. 1.
Causes for Dystocia. E. A. Boero.—p. 3. Cont'n.
Lethargic Encephalitis. J. A. Petrocchi and A. Hardoy.—p. 13.
Chronic Osteitis of Upper Jaw. A. M. Cavazzutti.—p. 17.
Artificial Production of Cells. A. L. Herrera.—p. 20.
Puerperal Inversion of Uterus. S. Cerruti.—p. 21.

Siglo Médico, Madrid

Aug. 14, 1920, 67, No. 3479

Postinfectious Phenomena. B. González Alvarez.—p. 605.
Congenital Cyst in Neck Infected from Throat. J. M. Barajas de Vilches.—p. 608. Begun in No. 3478, p. 587.
Acute Cardiac Insufficiency with Permanently High Blood Pressure. Elizagaray.—p. 611. Begun in No. 3476, p. 549.

Beiträge zur klinischen Chirurgie, Tübingen

1920, 120, No. 3

*Coagulation of the Blood in Jaundice. G. Petrén.—p. 501.
*Reconstruction of Thumb. O. Kleinschmidt.—p. 589.
Anatomy for Reconstruction of Thumb. W. Müller.—p. 595.
Accessory Bone Formation at the Patella. W. Müller.—p. 599.
*Deep Roentgen-Ray Treatment of Sarcomas. A. Schlegel.—p. 605.
Iodin Treatment of Mucosa at Laparotomies. L. Frankenthal.—p. 614.
Experimental Gas Gangrene. S. Weil.—p. 627.
Subserous Hematomas. R. Sommer.—p. 641.
Luxation of Joint at Base of Finger or Toe. W. Strube.—p. 646.
*Primary Benign Tumors in Muscles. E. König.—p. 656.
Migration of Projectiles. M. Flesch-Thebesius.—p. 663.

Coagulation of Blood in Jaundice.—Petrén foretells the cases in which there is liable to be postoperative cholemic hemorrhage, and its intensity, by estimation of the coagulation property of the blood. He thinks it is indispensable to ascertain the coagulation time of the blood in all persons who have been having jaundice for three or four weeks, before attempting a laparotomy. A simple test for the purpose is with what he calls "bile acid alkali." This is made by drawing 9 c.c. of blood from the vein into a syringe containing 1 c.c. of a 1 per cent. solution of ammonium oxalate. The fluid is then transferred to a reagent glass and shaken up, allowed to stand for a few hours and then centrifuged. The oxalate plasma thus obtained is treated with different amounts of a solution of crystallized fel bovis or human bile, and the coagulation time is recorded after addition of a little calcium (0.05 c.c. of a 1 per cent. solution of calcium chlorid to each 0.2 c.c. of the plasma). The findings are tabulated from seventy-seven healthy controls and twenty-eight jaundice patients. They show that from 0.55 to 0.66 per cent. of the bile acid alkali is necessary to prevent coagulation in the healthy. When this amount is required there is little danger of cholemic hemorrhage. But if coagulation occurs with 0.45 or 0.40 per cent. there is danger of hemorrhage, and with 0.30 per cent. or less there is such grave danger of cholemic hemorrhage that the operation is contraindicated. The bile acid content of the blood was low in three fatal cases of cholemic hemorrhage which had responded positively to the bile acid alkali test, testifying that the cause for the hemorrhage must be sought elsewhere than in the bile acids in the blood. He commends this principle of testing the concentration at which a coagulation-checking substance acts, as freer from sources of error than other methods.

Reconstruction of the Thumb.—Kleinschmidt's illustrations confirm his statements as to the superiority of the method for reconstructing the thumb by transplanting the middle finger to the stump of the thumb. The hand is very little disfigured, while functioning is most satisfactory.

Deep Roentgen-Ray Treatment of Sarcoma.—Schlegel reports brilliant success in six cases of sarcoma in different parts of the body.

Primary Tumors in Muscles.—The tumor in one of the two cases reported by König was a soft lipoma in the lateral head of the triceps; in the other, a mixed lipoma and angioma in the semimembranosus.

Deutsche medizinische Wochenschrift, Berlin

Sept. 16, 1920, 46, No. 38

Toxin-Destroying Effect of Lecithin. H. Leo.—p. 1045.
Toxins and Antitoxins of Cholera Vibrio. R. Kraus.—p. 1046.
Treatment of Diphtheria with Normal Horse Serum. Meyer.—p. 1048.
Osteomyelitis of the Hyoid Bone. F. Lotsch.—p. 1049.
Cerebral Disturbances Following Ligation of Common Carotid Artery. H. Moses.—p. 1050.
Anthelmintic Effect of Certain Phenols. W. Schulemann.—p. 1050.
Mediastinal Emphysema and Stenosis in Influenza. Gehrt.—p. 1052.
Blood Platelets. E. Brieger.—p. 1053.
Lavage Preceding Treatment with Ultraviolet Rays. Ladebeck.—p. 1055.
A Modern Type of Neon Lamp. Axmann.—p. 1056.
Present Status of Endocrinology. L. Asher.—p. 1056. Begun in No. 37.
Otologic Hints for the General Practitioner: Care of Partially Deaf Schoolchildren. G. Brühl.—p. 1057.

Monatsschrift für Geb. und Gynäkologie, Berlin

September, 1920, 52, No. 3

*Management of Brow Presentation. B. Schwarz.—p. 153.
*Obstetric Examination Through the Rectum. F. Jaeger.—p. 160.
Bactericidal Properties of Wound Secretions for Bacteria of Amniotic Fluid at Delivery. F. Schreiner.—p. 166.
*High Retroperitoneal Cystomas. B. Schweitzer.—p. 171.
Loose Dermoid Cystoma in Abdominal Cavity. K. Kayser.—p. 180.
*Hypoplasia and Tumor. Tschirdewahn.—p. 186.
Case of Malformation of Müller's Ducts. Samson.—p. 190.
Dicephalous Monster. R. Zimmermann.—p. 194.

Management of Brow Presentation.—Schwarz reports six cases of brow presentation which confirm him in the advocacy of subcutaneous symphyseotomy when it is impossible to modify the presentation and haste is imperative. He introduces the forceps, but if moderate traction twice applied does not answer the purpose, he leaves the forceps in place and proceeds to subcutaneous symphyseotomy, supplemented by pubiotomy in case of primiparae. Conservative measures can thus be carried to the extreme.

Obstetric Rectal Examination.—Jaeger presents a number of arguments in favor of restricting examination to what can be learned from without, and through the rectum. But he does not advise teaching it to students, as it requires a thorough knowledge of examination through the vagina to start with. The physician must learn the rectal technic himself, but once mastered, it is as instructive as the vaginal.

Retroperitoneal Cystomas.—In Schweitzer's two cases the genitals were normal but the high retroperitoneal tumors had the aspect and structure of ovarian cysts. The patients were women of 41 but cases are known in men. The tumors were as large as a man's head and one had been six years in developing; the other had grown more rapidly.

Hypoplasia and Tumor.—Tschirdewahn removed a large hard tumor from the pouch of Douglas of a woman of 26. It had developed from the ovary, and the internal genitals were of a pronounced infantile type. He implanted parts of an ovary just removed from another patient before suturing the abdomen. The young woman had never menstruated. He discusses whether the hypoplasia was the result of the tumor or vice versa.

Münchener medizinische Wochenschrift, Munich

Sept. 3, 1920, 67, No. 36

*Structure of the Dermal Epithelium. W. Frieboes.—p. 1031.
Mushroom Poisoning. G. Blank.—p. 1032.
Wassermann and Sachs-Georgi Reaction in Syphilis. Baumgärtel. —p. 1034.
Mode of Action of Psychotherapy. Von Hattingberg.—p. 1037.
*Primary Seronegative Syphilis. Meirowsky and Leven.—p. 1040.
Deep Thermometry. V. B. Zondek.—p. 1041.
*Kineplastic Operations. M. Cohn.—p. 1042.
Foot and Mouth Disease in Man. H. Kopf.—p. 1043.
*Vomiting at Onset of Appendicitis. V. E. Mertens.—p. 1043.
Urticaria Tuberosa (Willan). F. Reiche.—p. 1044.
Primary Actinomycosis of the Tongue. Kockel.—p. 1044.
Mercury Inunctions. K. Taege.—p. 1045.
Effect of Combined Radium Preparations. W. Lahm.—p. 1045.
Apparatus for Deep Roentgenotherapy. Baumeister.—p. 1047.
Staining of Spirochaeta Pallida in Thick Drop. Saphier.—p. 1047.
"Therapeutic Effects of Induced Pneumoperitoneum." Fuld.—p. 1048.

Epithelial Covering of the Skin.—Frieboes discusses the embryonic structure of the epithelium, endeavoring to show that it is not of purely ectodermal origin, but that it is derived from the ectoderm and the mesenchyma, and that these two germinal layers have an equal part in its composition.

Unsuccessful Abortive Treatment of Primary Seronegative Syphilis.—The fact that three of their patients with a negative Wassermann reaction during the primary stage had recurrences of neurosyphilis in spite of so-called abortive treatment, leads Meirowsky and Leven to state that, although the Wassermann test applied to both the blood and the spinal fluid may be negative, syphilis may still persist. For this reason it is evident that we have as yet no absolutely reliable means of knowing whether or not our treatment has been successful. The problem to be solved now is to find some means of ascertaining the cure beyond all question. In the meantime we must give up trying to establish a definite schedule of treatment, and must treat each case on its merits on the basis of our previous experience.

Kineplastic Operations.—While Cohn does not approve of the kineplastic operation as the procedure of choice, he emphasizes that the method introduced in Germany by Sauerbruch more fully meets the demands, from a technical standpoint, than the Italian procedure as recommended by Vanghetti. Sauerbruch, himself, admits that to Vanghetti belongs the honor of having been the first to consistently advance the idea of kinetic prosthesis. This was some twenty years ago. Only recently, as already mentioned elsewhere, the academy of Turin awarded Vanghetti the Riberi prize of 20,000 liras for his work in this field.

Significance of Vomiting with the Onset of Appendicitis.—Mertens emphasizes that if appendicitis begins with pain and vomiting the indications for operation are incontrovertible, as gangrene or suppuration must be present. The fact that pulse and temperature are not alarming is not a contraindication for operation.

Sept. 10, 1920, **67**, No. 37

Diagnosis and Treatment of Influenza. Much et al.—p. 1057.
Course of Leukemia After Spleen Extirpation. Toenniessen.—p. 1059.
Biologic Effects of Vitamins. Freudenberg and György.—p. 1061.
Examination of Undernourished German Children. Bloch.—p. 1062.
Accelerated Coagulation of the Blood as Result of Thermopenetration Applied to the Spleen. Nonnenbruch and Szyszka.—p. 1064.
Thermopenetration in Neuritis. Schwalbach and Bucky.—p. 1065.
General Narcosis Much Facilitated by Induced Relative Anemia in Brain. Hofmann.—p. 1065.
Effect of Types of Gonococcus on the Infection. Jötten.—p. 1067.
Thiosinamin. W. Stoeltzner.—p. 1070.
The Three Centuries of Treatment of Gunshot Wounds After Pfohlspeundt (1460). Kritzler.—p. 1070.

Wiener klinische Wochenschrift, Vienna

Sept. 2, 1920, **33**, No. 36

Gonorrhea in Women. Bucara.—p. 789.
Behavior of Typhus Virus in Guinea-Pigs. Weil and Felix.—p. 794.
Influenza in Relation to Syphilis. P. Neuda.—p. 796.
Relation of Influenza and Syphilis. M. Strasberg.—p. 797.
Protein Therapy. H. Hayek.—p. 798. Begun in No. 35, p. 768.

Zentralblatt für Chirurgie, Leipzig

Sept. 11, 1920, **47**, No. 37

*Steinach's Rejuvenation Operation. E. Payr.—p. 1130.
*Skin Flaps to Bridge Defects. Hammesfahr.—p. 1139.
Fastening of Retention Catheter with Suture. Schultze.—p. 1141.

Steinach's Rejuvenation Operation.—To certain portions of genital glands Steinach applies the term "puberty gland," which corresponds to Leydig's cells—the interstitial cells of the testis—and to the interstitial substance of the ovary (lutein cells). Through experimentation we have learned that the endosecretory portions, the "puberty gland," are much more resistant to outside harm than are the generative portions of the genital glands. By the successful transplantation of the endosecretory portions from one individual to another, important facts in regard to the secondary sexual characters have been learned. Here we have, then, the basis for Steinach's procedure. By stimulation of the endosecretory action of the puberty gland at the expense of the generative function it is his idea to bring about a rejuvenating process in older people by the resuscitation and renewal of the weakening secondary sexual characters. In his latest communication Steinach describes two types of intervention: (1) ligation of the vas deferens where it merges with the epididymis, and (2) ligation of the ductuli efferentes (coni vasculosi) between the head of the epididymis and the upper pole of the testis. The latter leaves the blood vessels supplying the testis unimpaired. Payr remarks that, owing to gonorrhea or trauma adhesions are often present which render the second type of operation difficult. He gives what he would consider at present the contraindications for the Steinach operation: (1) well preserved power to produce spermatozoa; (2) need of special caution in excitable, depressed or mentally disturbed subjects; (3) enlargement of the prostate (prostatectomy, also a rejuvenating operation, being indicated instead); (4) other organic causes for premature old age, with marked changes in the heart, blood vessels, kidneys, pancreas, intestine, etc.; (5) occlusion of the vas deferens due to previous disease (gonorrhea), and (6) gradual deterioration of the secondary sexual characters owing to chronic disease of a different nature; for example, dystrophia adiposo-genitalis. Steinach's operation might be regarded as indicated in the case of subjects with healthy internal organs who are growing prematurely old and who, at the same time, show evidence of loss of function by their impaired secondary sexual characters. In doubtful cases roentgen irradiation should be tried before surgical operation is decided on. Only by such precautions can the threatening dangers, which Payr describes in detail, be avoided.

Narrow Pedunculated Skin Flaps to Bridge Large Defect.—A feature of the method described by Hammesfahr seems to be that from the same site as many flaps as needed can be taken without leaving a gap. He cuts a skin flap about 3 cm. wide from the healthy area adjoining the defect, seeing to it that the flap is of good thickness and well supplied with blood vessels, sometimes including fascia and muscles. The end of the flap farthest from the defect is first notched and later severed entirely from its connections, and on the end nearer to the defect as a pedicle it is swung around and laid across the middle portion of the wound area, being sutured at both ends in a groove that has been prepared in the healthy, well vascularized tissue surrounding the defect, as shown in the illustration. The site from which the flap is taken must be sutured at once, exactly and without tension, so that in two weeks another flap can be taken from the same place, and two weeks later a third, and so on until the defect is sufficiently covered. Flaps up to 20 cm. in length can be prepared at one sitting. If longer flaps are required, it is best to form the flap in two or more stages by lengthening the end more distant from the defect by about 15 cm. at each sitting. It is well to make the end of the flap next to the defect somewhat hookshaped (illustration) to prevent its crumpling when it is swung around.

Pedunculated flaps to bridge defect.

Zentralblatt für Gynäkologie, Leipzig

Sept. 11, 1920, **44**, No. 37

Relation of Diphtheria Bacilli in Vagina of Healthy Prospective Mothers to Infection of Newborn. Lönne and Meyeringh.—p. 1018.
Cure of Bladder Fistula by Uterovaginal Interposition of Plica. E. Sohns.—p. 1022.
Plastic Changes in Body of Uterus. J. Schiffmann.—p. 1028.

Zentralblatt für innere Medizin, Leipzig

Sept. 11, 1920, **41**, No. 37

Mechanicophysical Aspects of the Spinal Fluid. E. Becher.—p. 633.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

Aug. 28, 1920, **2**, No. 9

Individuality and Mental Derangement. Van Valkenburg.—p. 762.
*Malaria in Netherlands Indies. N. H. Swellengrebel.—p. 770.
*Bilateral Paralysis of Femoral Plexus from Abdominal Tumor. J. J. H. M. Klessens.—p. 787.

Malaria in Netherlands Indies.—This report from the section for tropical hygiene of the Colonial Institute at Amsterdam summarizes and tabulates the results of research most of which has been reviewed in these columns as published from time to time in the quarterlies issued by the public health service in the Netherlands Indies. The outlook for eradication of "ludlow malaria" in the zones where this species of mos-

quito is responsible, is more promising than with the aconita and maculatus. The breeding habits of these two render their extermination almost hopeless. The indefinita seems to be harmless, and there is hope that the annulipes is also. To reenforce all other measures, extensive quininization, especially of schoolchildren, is urged. To eradicate the severe endemic malaria the fight has to be against *M. ludlowi*, and *aconita; N. maculatus* and possibly *S. aitkeni*.

The Early Symptoms from a Suprarenal Tumor.—Klessen's patient was a woman of 50 who for a year had complained of paresthesia in the front of the right leg, and it became impossible to bend the hip and knee. Other nervous symptoms developed indicating pressure on both femoral nerves at the level of the pelvic inlet. The enlarged veins in the skin confirmed the assumption of a tumor, and the enlargement of the regional lymph glands suggested its malignant character. The ureter seemed to have escaped pressure but cystitis had developed. These early complex neurologic symptoms from the suprarenal cancer are described in detail. Some benefit was derived from roentgen-ray exposures but it proved transient, and this had to be abandoned. The bronzing suggested that the suprarenal was the site of the tumor, confirmed also by lack of symptoms from other organs, but necropsy was not allowed.

Hospitalstidende, Copenhagen

Nov. 5 to Dec. 10, 1919, **62**, Nos. 45-50

*Precancerous Dermatosis. A. Korsbjerg.—p. 1233.
Influenza-Encephalitis. G. Neve.—p. 1257.
*Chronic Serous Meningitis. V. Christiansen.—p. 1281.
*Achylia After Cholecystectomy. M. Fenger.—p. 1305.
Phototherapy in Ophthalmology. C. Lottrup-Andersen. — p. 1316. Begun in No. 44, p. 1217.
*Weiss' Test for Circulatory Apparatus. K. Secher.—p. 1329.
Diplococcus Infection and Meningitis. H. Seidelin.—p. 1336.
*Case of Acute Hemorrhagic Pancreatitis. J. Henrichsen.—p. 1353.
Massage. P. Lorenzen.—p. 1361.

Precancerous Dermatosis.—Korsbjerg gives a description of a skin disease which after eight years developed malignant characteristics and which he retrospectively diagnosed as Bowen's precancerous dermatosis. This makes the eighth case of the kind to be published; the interval from the first manifestations was from four to forty years in the different cases. The dermatosis resembles certain forms of lichen and syphilids as also Paget's disease, and it occurs in one or more foci, not symmetrical, and with no predilection for any special region. Epithelioma developed in four of the eight cases. No internal or roentgen-ray treatment seems to have any effect. Carbon dioxid snow was used in two cases but the dermatosis returned in one, sixteen months later. Darier destroyed the patch with superheated air in one case but the outcome later is not known. The microscope reveals the similarity to Paget's disease. The single lesions are round, flat, generally hard, sometimes with a slight central depression, reddish or yellowish, without a halo. They range from 1 or 3 mm. to 0.5 cm. in diameter, and progress with a serpiginous course and film-like scales, with crusting. In the case described the papular lesions partially subsided under local mercurial treatment, but as new patches developed elsewhere, excision has been advised. Darier calls the disease *dyskératose lenticulaire et en disque*, but Korsbjerg prefers Bowen's name for it as featuring its eventual malignant degeneration.

Chronic Circumscribed Serous Meningitis.—Christiansen has never encountered serous meningitis in the posterior cranial fossa as an isolated pathologic condition; it always accompanied a tumor in the cerebellum or pontine angle. He found it constantly in the twenty cases of tumor in this region which he has diagnosed in the last six years, but it occurs also with tumors elsewhere in the skull. It should always impose a search for intracranial tumor even when no other symptoms suggest the latter, and thus may lead to discovery of an incipient tumor.

Achylia After Cholecystectomy.—Fenger tabulates the findings in 115 gallstone patients and in seventy-five before and after cholecystectomy. They fail to demonstrate any influence on the gastric secretion from obstruction of the bile ducts or from removal of the gallbladder, any more than from cholelithiasis in general.

Weiss' Test of Functional Capacity of Circulatory System.—Secher's experience failed to confirm the assertions of Weiss.

Acute Hemorrhagic Pancreatitis.—The symptoms suggested peritonitis from perforation, but as there was nothing in the antecedents to suggest gastric ulcer or gallstones, and as the sudden onset and collapse pointed to the pancreas, the necrotic pancreas was removed three weeks after the first symptoms. It lay like a loose sequester, and Henrichsen is inclined to regard the loss of this important organ as responsible for the fatal outcome. No gallstones could be palpated at the operation but over a dozen were found at necropsy. The pancreatectomy improved conditions remarkably at first, instead of increasing the shock, and death did not occur till three weeks later. A special feature of the case was the intense response to tests for sugar in the urine before the operation.

Hygiea, Stockholm

Oct. 16, 1920, **82**, No. 19

*Pathologic Anatomy of Congenital Stridor. W. Wernstedt.—p. 609.
*Turgidization of Placenta. W. Gejrot.—p. 622.

Congenital Stridor.—Wernstedt compares the necropsy findings in two infants with congenital stridor with the findings in other infant cadavers. One seemed to be a functional disturbance; in the other case the lumen was abnormally narrow.

Injection of Fluid Into Placenta to Aid in Its Separation.—Gejrot ascribes the priority for turgidization of the placenta to B. Mojon, a professor at Genoa in 1826. It was rediscovered by Gabastón of Buenos Aires, as was described at the time in THE JOURNAL, May 2, 1914, p. 1443. Gejrot has been applying the measure systematically for a year in all cases of retention or severe hemorrhage in the third stage of labor. He injected into the umbilical vein from 300 to 600 c.c. of cool water. It proved successful in 5 of the 7 retention cases; in the others the patient was too exhausted to respond. In 4 of the 7 severe hemorrhage cases the desired result was obtained; in the others it failed. In the 9 cases in which it succeeded, the placenta became turgid and in erection, and vigorous contractions of the uterus followed at once. The temperature of the water was about 14 C. or 57 F.

Ugeskrift for Læger, Copenhagen

Oct. 21, 1920, **82**, No. 43

*Syphilis of the Outer Ear. R. Lund.—p. 1335.
Wassermann Reaction in Children. R. Hertz.—p. 1343.

Syphilis of the External Ear.—Lund encountered 18 cases of this kind in the last year. The syphilis was in the second or third phase in all; most of the patients were women. In 30 cases on record the primary chancre was on the ear. In one of his cases the papulous eruption in the external ear, without otitis media, was the only manifestation of the syphilis to be discovered. The diagnosis was based exclusively on the aspect of the eruption and the improvement under specific treatment. Among his 4 tertiary cases, in 2 there were gummas in the skin of the ear which left scars as they healed; in one the gummatous chondritis was very destructive, the gummas following close on the secondary eruption, the infection less than a year old. These lesions on the ear differ from such lesions elsewhere only in the disfigurement liable to result.

Oct. 28, 1920, **82**, No. 44

*Sugar Content of Blood Under Ether. D. H. Bøggild.—p. 1365.
Treatment of Status Epilepticus. E. Toft.—p. 1370.

Sugar Content of the Blood During Ether Anesthesia.—Bøggild tabulates the findings before and after an operation under ether in thirty-three cases and in five under local anesthesia. More or less of an increase in the reducing power of the blood after the ether anesthesia and the operation was evident in all but two. The increase was from 0.85 to 1.47 per thousand immediately after the operation in one case, but the previous figure was regained by the seventh hour. In another case the increase was from 0.87 before to 1.35 the fifth and 1.46 the tenth hour. He theorizes to explain this postnarcosis hyperglycemia, adding that it suggests a resemblance between the effects of ether and diabetes mellitus.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JULY-DECEMBER, 1920

The following journals have been abstracted in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

Acta Medica Scandinavica. Irregular. 20 kronor. Stockholm.
Acta Scholae medicinalis universitatis imperialis in Kioto. Irregular. 2.30 yen. Kioto.
American Journal of Anatomy. Bi-m. $7.50. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Ophthalmology. M. $10. 7 W. Madison St., Chicago.
American Journal of Physiology. M. $5. Johns Hopkins Medical School, Baltimore.
American Journal of Public Health. M. $4. 169 Massachusetts Ave., Boston.
American Journal of Roentgenology. M. $6. 69 E. 59th St., New York.
American Journal of Syphilis. Q. $6. C. V. Mosby Co., St. Louis.
American Review of Tuberculosis. M. $5. Williams & Wilkins Co., Baltimore.
Anales de la Facultad de medicina, Montevideo. Bi-m. $2. Montevideo.
Anales de la Facultad de medicina, Universidad de Lima. Bi-m. 6 soles. Lima, Peru.
Annales de médecine. M. 40 francs. Paris.
Annali d'igiene. M. 20 lire. Rome.
Annals of Medical History. Q. $8. Paul B. Hoeber, 67 E. 59th St., New York.
Annals of Medicine. Q. $10. W. F. Prior Co., 22 East 17th St., New York.
Annals of Otology, Rhinology and Laryngology. Q. $6. Times Bldg., St. Louis.
Annals of Surgery. M. $7.50. J. B. Lippincott Co., 227 S. 6th St., Philadelphia.
Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.
Arbeiten aus dem Anatomischen Institut der Kaiserlich-Japanischen Universität zu Sendai. Irregular. Price varies. Tokyo.
*Archiv für Gynaekologie. Irregular. Berlin.
Archiv für Kinderheilkunde. Irregular. 30 marks. Stuttgart.
*Archiv für klinische Chirurgie. Irregular. Berlin.
Archiv für Verdauungskrankheiten. Bi-m. 36 marks. Berlin.
Archives of Dermatology and Syphilology. M. $6. American Medical Association, 535 N. Dearborn St., Chicago.
Archives of Diagnosis. Q. $3. 141 W. 36th St., New York.
Archives of Internal Medicine. M. $5. American Medical Association, 535 N. Dearborn St., Chicago.
Archives des maladies de l'appareil digestif et de la nutrition. M. 28 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 22 francs. Paris.
Archives médicales belges. M. 18 francs. Paris.
Archives de médecine des enfants. M. 30 francs. Paris.
Archives of Neurology and Psychiatry. M. $6. American Medical Association, 535 N. Dearborn St., Chicago.
Archives of Ophthalmology. Bi-m. $6. G. P. Putnam's Sons, 2 W. 45th St., New York.
Archives of Radiology and Electrotherapy. M. 30 shillings. London.
Archivos españoles de pediatria. M. 18 pesetas. Madrid.
Archivos Latino-Americanos de pediatria. Bi-m. $3. Buenos Aires.
Arquivos do Instituto bacteriológico Camara Pestana. Price varies. Lisbon.
Boston Medical and Surgical Journal. W. $5. 126 Massachusetts Ave., Boston.
Brain. A Journal of Neurology. Irregular. $4. London.
Brazil-medico. W. 20 milreis. Rio de Janeiro.
Bristol Medico-Chirurgical Journal. Irregular. 3 shillings per issue.
British Journal of Children's Diseases. Q. 7 shillings, 6 pence. London.
British Journal of Experimental Pathology. Bi-m. £2. London.
British Journal of Surgery. Q. $6.50. William Wood & Company, 51 Fifth Ave., New York.
British Journal of Tuberculosis. Q. $2.50. G. E. Stechert & Co., 151 W. 25th St., New York.
British Medical Journal. W. 8d per issue. London.
Bruns' Beiträge zur klinischen Chirurgie. Irregular. Price varies. Tubingen.
Bulletin de l'Académie de médecine. W. 23 francs. Paris.
Bulletin médical. Semi-w. 14 francs. Paris.
Bulletin of the Johns Hopkins Hospital. M. $3. Baltimore.
Bulletin of the Lying-In Hospital of the City of New York. New York.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. (except June, July, August and September) 25 cents. 1211 Cathedral St., Baltimore.
Bulletin of the Naval Medical Association of Japan. Irregular. Tokio.
Bulletin of the Porto Rico Medical Association. Q. San Juan, Porto Rico.
Bulletins et mémoires de la Société médicale des Hôpitaux de Paris. W. 40 francs. Paris.
California State Journal of Medicine. M. $1. Butler Bldg., San Francisco.
Canadian Journal of Mental Hygiene. Q. $2. 121 Bishop St., Montreal.
Canadian Medical Association Journal. M. $5. 836 University St., Montreal.
China Medical Journal. Bi-m. $5. Shanghai.
Chirurgia degli organi di movimento. Bi-m. 35 lire. Bologna.
Colorado Medicine. M. $2. Metropolitan Bldg., Denver.
Correspondenz-Blatt für schweizer Aerzte. See Schweizerische medizinische Wochenschrift.
Crónica médica. Semi-m. 15 francs. Lima, Peru.
Delaware State Medical Journal. M. $1. Wilmington.
Deutsche medizinische Wochenschrift. W. $6. Leipzig.
Deutsche Zeitschrift für Chirurgie. Irregular. 28 marks. Leipzig.
Deutsches Archiv für klinische Medizin. M. 24 marks. Leipzig.
Dublin Journal of Medical Science. M. £1.5s.
Edinburgh Medical Journal. M. 40 shillings.
L'Encéphale. M. 70 francs. Paris.
Endocrinology: Bulletin of the Association for the Study of Internal Secretions. Q. $5. 1100-1103 Title Insurance Bldg., Los Angeles.
Finska Läkaresällskapets Handlingar. Bi-m. Helsingsfors.
Gaceta médica de Caracas. Semi-m. 16 bolivares. Caracas, Venezuela.
Gaceta médica de México. Irregular. $6. Mexico City.
Gann. Irregular. Tokio.
Glasgow Medical Journal. M. 30 shillings.
Grèce médicale. Semi-m. 12 francs. Athens.
Hospitalstidende. W. 27.5 kronen. Copenhagen.
Hygiea. Semi-m. $5. Stockholm.
Illinois Medical Journal. M. $3. 155 N. Ridgeland Ave., Oak Park.
Indian Journal of Medical Research. Q. 10s. Calcutta.
Indian Medical Gazette. M. Rs. 16. Calcutta.
International Journal of Psycho-Analysis. Q. London.
International Journal of Public Health. Bi-m. $5. Geneva.
Jahrbuch für Kinderheilkunde und physische Erziehung. Irregular. 32 marks. Berlin.
Japan Medical World (Nippon No Ikai). W. Tokio.
Journal of the American Medical Association. W. $6. 535 N. Dearborn St., Chicago.
Journal of the Arkansas Medical Society. M. $2 Boyle Bldg., Little Rock, Ark.
Journal of Bacteriology. Bi-m. $5. Williams & Wilkins Company, Baltimore.
Journal of Biological Chemistry. M. $3. 2419 Greenmount Ave., Baltimore.
Journal of Cancer Research. Q. $5. Williams & Wilkins Company, Baltimore.
Journal de chirurgie. M. 44 francs. Paris.

W.—Weekly; M.—Monthly; Semi-m.—Semi-monthly; Bi-m.—Bi-monthly; Q.—Quarterly. * Cannot be loaned.

Journal of Experimental Medicine. M. $5. Rockefeller Institute for Medical Research, 66th St. and Avenue A, New York.
Journal of the Florida Medical Association. M. $1.50. P. O. Box 136, Jacksonville, Fla.
Journal of General Physiology. Bi-m. $5. Rockefeller Institute for Medical Research, 66th St., and Avenue A, New York.
Journal of Immunology. Bi-m. $5. Williams & Wilkins Company, Baltimore.
Journal of the Indiana State Medical Association. M. $2. 406 W. Berry St., Fort Wayne, Ind.
Journal of Industrial Hygiene and Abstract of the Literature. M. $6. Harvard University Press, Cambridge, Mass.
Journal of Infectious Diseases. M. $5. 637 S. Wood St., Chicago.
Journal of Iowa State Medical Society. M. $2.50. Des Moines.
Journal of Kansas Medical Society. M. $2. 303 Commerce Bldg., Topeka, Kan.
Journal of Laboratory and Clinical Medicine. M. $6. C. V. Mosby Company, St. Louis.
Journal of Laryngology, Rhinology and Otology. M. 40 shillings. London.
Journal of Maine Medical Association. M. $2. Portland, Maine.
Journal of Medical Association of Georgia. M. $3. Healy Bldg., Atlanta, Ga.
Journal of Medical Research. Bi-m. $4. 240 Longwood Ave., Boston.
Journal of Medical Society of New Jersey. M. $2. 12 Cone St., Orange, N. J.
Journal de médecine de Bordeaux. M. 15 francs.
Journal of Mental Science. Q. 20 shillings. London.
Journal of Michigan State Medical Society. M. $3.50. Powers' Theatre Bldg., Grand Rapids, Mich.
Journal of Missouri State Medical Association. M. $2. 3517 Pine St., St. Louis.
Journal of Nervous and Mental Diseases. M. $10. 64 W. 56th St., New York.
Journal of Neurology and Psychopathology. Q. 30 shillings. Bristol, England.
Journal of Oklahoma State Medical Association. M. $3. Muskogee.
Journal of Orthopaedic Surgery. M. $4. Lincoln, Nebraska.
Journal of Parasitology. Q. $3. Urbana, Ill.
Journal of Pathology and Bacteriology. Irregular. £1.1s. Cambridge, England.
Journal of Pharmacology and Experimental Therapeutics. M. $6. 2419 Greenmount Ave., Baltimore.
Journal de radiologie et d'électrologie. M. 28 francs. Paris.
Journal of South Carolina Medical Association. M. $2. Greenville, S. C.
Journal of State Medicine. M. 2 shillings. London.
Journal of Tennessee State Medical Association. M. $2. 601 Cedar St., Nashville, Tenn.
Journal of Tropical Medicine and Hygiene. Semi-m. 21 shillings. London.
Journal d'urologie médicale et chirurgicale. M. 42 francs. Paris.
Journal of Urology. Bi-m. $5. Williams & Wilkins Co., Baltimore.
Kentucky Medical Journal. M. $2. State and Twelfth Sts., Bowling Green, Ky.
Kitasato Archives of Experimental Medicine. Twice a year. 60 cents. Tokio.
Lancet. W. 10d per issue. London.
Laryngoscope. M. $6. 3858 Westminster Place, St. Louis.
Lyon chirurgical. M. 25 francs.
Lyon médical. Semi-m. 15 francs.
Médecine. M. 18 francs. Paris.
Mededeelingen van den Burgerlijken Geneeskundigen Dienst in Nederlandsch-Indië. Irregular. Price varies. Batavia, Java.
Medical Journal of Australia. W. 6 d. Sydney.
Medical Journal of the Siamese Red Cross. 5 ticals. Bangkok.
Medical Journal of South Africa. M. £1.5. Johannesburg.
Medical Record. W. $5. W. Wood & Co., 51 Fifth Ave., New York.
Medizinische Klinik. W. 60 marks. Berlin.
Mental Hygiene. Q. $2. National Committee for Mental Hygiene, 50 Union Square, New York City.
Military Surgeon. M. $4. Army Medical Museum, Washington, D. C.
Minnesota Medicine. M. $3. Lowry Bldg., St. Paul.
*Mitteilungen aus den Grenzgebieten der Medizin und Chirurgie. Irregular. Jena.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität Kyushu. Irregular. Price varies. Fukuoka.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität zu Tokyo. Irregular. Price varies. Tokio.
Modern Hospital. M. $3. 22 E. Ontario St., Chicago.
Modern Medicine. M. $3. 22 E. Ontario St., Chicago.
Monatsschrift für Geburtshülfe und Gynäkologie. M. 40 marks. Berlin.
Monatsschrift für Kinderheilkunde. M. Berlin.
Münchener medizinische Wochenschrift. W. $6. Munich.
National Medical Journal of China. $2.50. Shanghai.
Nebraska State Medical Journal. M. $2.00. 468 Brandeis Bldg., Omaha.
Nederlandsch Tijdschrift voor Geneeskunde. W. 10.50 florins. Amsterdam.
Neurological Bulletin. M. $5. Paul B. Hoeber, 69 E. 59th St., New York.
New Orleans Medical and Surgical Journal. M. $2.50. 1551 Canal St., New Orleans.
New York Medical Journal. W. $6. A. R. Elliott Publishing Co., 66 W. Broadway, New York.
New York State Journal of Medicine. M. $2. 17 W. 43d St., New York.
Norsk Magazin for Lægevidenskaben. M. $5. Christiania.
Northwest Medicine. M. $2. Cobb Bldg., Seattle, Wash.
Nourrisson. Bi-m. 14 francs. Paris.
Ohio State Medical Journal. M. $3. Physician's Bldg., Columbus.
Paris médical. W. 16 francs.
Pediatria. Bi-m. 20 lire. Naples.
Pennsylvania Medical Journal. M. $2. 212 N. Third St., Harrisburg.
Philippine Journal of Science. Monthly. $5. Manila, P. I.
Policlinico. W. 32 lire. Rome.
Practitioner. M. $6.50. London.
Presse médicale. Semi-w. 15 francs. Paris.
Progrès médical. W. 12 francs. Paris.
Psychobiology. Bi-m. $5. Williams & Wilkins Co., Baltimore.
Public Health Journal. M. $2. York Publishing Co., 169 Bay St., Toronto.
Quarterly Journal of Medicine. 25 shillings. London.
Revista de la Asociación médica argentina. M. Buenos Aires.
Revista de la Universidad de Buenos Aires. M. $5. Buenos Aires.
Revista del Instituto bacteriológico. Q. Buenos Aires.
Revista médica del Uruguay. M. 30 francs. Montevideo.
Revue de chirurgie. M. 33 francs. Paris.
Revue de médecine. M. 23 francs. Paris.
Revue médicale de la Suisse romande. M. 14 francs. Geneva.
Rhode Island Medical Journal. M. $2. 219 Waterman Street, Providence.
Riforma medica. W. 35.50 lire. Naples.
Revue mensuelle de gynécologie et d'obstétrique. M. 15 francs. Paris.
Revue neurologique. M. 45 francs. Paris.
Rivista critica di clinica medica. W. 16 lire. Florence.
Rivista di clinica pediatrica. M. 18 lire. Florence.
Schweizer Archiv für Neurologie und Psychiatrie. Irregular. Price varies. Zurich.
Schweizerische medizinische Wochenschrift. W. 17.20 francs. Basel.
Seale Hayne Neurological Studies. Irregular. 21 shillings. London.
Sei-I-Kwai Medical Journal. M. $2. Tokio.
Semana médica. W. $5. Buenos Aires.
Siglo médico. W. 20 pesetas. Madrid.
Social Hygiene. Q. $3. American Social Hygiene Association, 105 W. 40th St., New York.
South African Medical Record. Semi-m. 31 shillings 6 pence. P. O. Box 643, Capetown.
Southern Medical Journal. M. $3. 807 Empire Bldg., Birmingham, Ala.
Southwest Journal of Medicine and Surgery. M. $1. El Reno, Okla.
Southwestern Medicine. M. $2. El Paso, Texas.
Surgery, Gynecology and Obstetrics with International Abstract of Surgery. M. $12. Surgical Publishing Co., 30 N. Michigan Ave., Chicago.
Svenska Läkaresällskapets Handlingar. Q. 7.50 kroner. Stockholm.
Texas State Journal of Medicine. M. $2.50. Texas State Bldg., Fort Worth.
Therapeutische Halbmonatshefte. Semi-m. Berlin.
Tohoku Journal of Experimental Medicine. Issued six times a year. 5 yen. Sendai.
Tubercle. M. 25 shillings. London.
Ugeskrift for Læger. W. 20 kroner. Copenhagen.
United States Naval Medical Bulletin. Q. $1. Washington, D. C.
Upsala Läkareförenings Förhandlingar. Irregular. 10 kroner.
Virginia Medical Monthly. M. $2. Richmond.
Washington Medical Annals. Bi-m. $1. 2114 Eighteenth Street, N.W., Washington, D. C.
West Virginia Medical Journal. M. $2. Huntington, W. Va.
Wiener Archiv für innere Medizin. Irregular. Vienna.
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SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

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SOCIETIES

A.—Association
Acad.—Academy
Am.—American
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical or Medicine
Nat.—National
Phar.—Pharmaceutical
Phys.—Physicians
Ry.—Railway
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